

# Why is E-Filing Important?

- Faster Department of Labor (DOL) claims adjudication
- Expedited delivery of medical and compensation benefits
- More efficient data management
- E-Filing is more secure than paper-based filing
- Quicker nurse assignments on non-return to work (RTW) cases
- The Federal Employees Compensation Act (FECA) Regulations (20 CFR Part 10) require electronic filing by 12/31/2012.



# ECOMP OVERVIEW:

- ✓ Electronically file CA-1, CA-2, CA-7, or a CA-7a form from either a personal computer, a tablet, a cellphone, or a Postal computer.
- ✓ Electronically upload and submit documents to OWCP case files.
- ✓ Track forms submitted



# ECOMP FILING PROCESS:

- The employee registers for an account in ECOMP. Must have an email account and create a password.
- After registering, they file CA-1, CA-2, or CA-7 to claim FECA benefits.
- After submission of the form, it is routed to the supervisor for completion of page 2.
- After the supervisor completes their portion, the form is routed to the Agency Reviewer (Occupational Health Claims Office (OHC) within 24-hours ELM 544.11).
- Upon review by the OHC Office, the form is electronically submitted to OWCP within 10-business days ELM 544.212
- USPS may not delay submission ELM 545.75d
- OHC office may not delay under any circumstances EL 505 section 4.4



# BEWARE:

- Use of ECOMP via a USPS network allows management access to all your information.
- **Use of USPS network is not encouraged.**



# ECOMP Training Modules

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- Training modules are available on the ECOMP home page
- Printable text instructions
- Narrated videos demonstrating how to perform functions in ECOMP



# Welcome to ECOMP

The Employees' Compensation Operations & Management Portal

## Terms of Use

You are accessing a U.S. Government information system that is owned and operated by the Department of Labor. The Department of Labor information systems are provided for the processing of official U.S. Government information only, and are therefore, owned by the Department of Labor. Authorized users are responsible for the proper handling of information they access.

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## Have you been hurt on the job?

If you are a Federal Employee or a Contractor and have sustained a work-related injury or illness, use ECOMP to report the incident to your supervisor.

If you are a Federal Employee you may also file a claim for benefits under the Federal Employees' Compensation Act (FECA). Depending upon your agency, start by filing OSHA's Form 301, then file a claim using either form CA-1 (for traumatic injury) or form CA-2 (for occupational disease). After you have received an official FECA case number, you may also file form CA-7 (Claim for Compensation).

## Need to upload a document?

Stakeholders and interested parties can use ECOMP to upload documents to active FECA cases. You can upload letters, medical reports and other supporting documentation. You will need the official FECA Case Number and other identifying information to use this feature.

UPLOAD DOCUMENTS

## Medical Providers:

- Only medical reports can be submitted in ECOMP.

Do not upload bills in ECOMP as they will not be processed.

- Easily submit medical bills and reports in one electronic transaction using our free Direct Data Entry or Secure FTP. Refer to this [Quick Guide](#) for detailed steps. Learn all your options by clicking [here](#).

## Looking for a Pharmacy?

Click [here](#) to locate an in-network pharmacy in your area.

## Need to file a form?

Register for an account or sign in to get started!

### Sign In

Email or Username

Password

SIGN IN

[Forgot password?](#)

Need an account? [Register](#)

Track status of form or document

Enter ECN or DCN

TRACK STATUS

[www.ecomp.dol.gov](http://www.ecomp.dol.gov)



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Email or Username

Password

[SIGN IN](#)

[Forgot password?](#)

[Need an account? Register](#)

Track status of form or document

Enter ECN or DCN

[TRACK STATUS](#)

Click here to  
begin registration

[www.ecomp.dol.gov](http://www.ecomp.dol.gov)



# Claimant Registration



## REGISTER FOR ECOMP

Your ECOMP account enables you to file and manage forms with the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP). Your account is covered under the [Privacy Act](#). If you already have an account, [sign in here](#).

## ACCOUNT BASICS

First Name	Middle Name (optional)	Last Name
------------	------------------------	-----------

Home Telephone	<input type="checkbox"/> International
----------------	----------------------------------------

Email Address	?
---------------	---

Date of Birth

(mm)	(dd)	(yyyy)	
------	------	--------	--

Address	
City	State
ZIP code	Country
	UNITED STATES OF AMERICA
Social Security Number	Confirm SSN
<input type="checkbox"/> I do <b>NOT</b> have a Social Security Number and I am <b>NOT</b> a US Citizen.	

## PASSWORD

Choose a Password	Re-enter Password
-------------------	-------------------

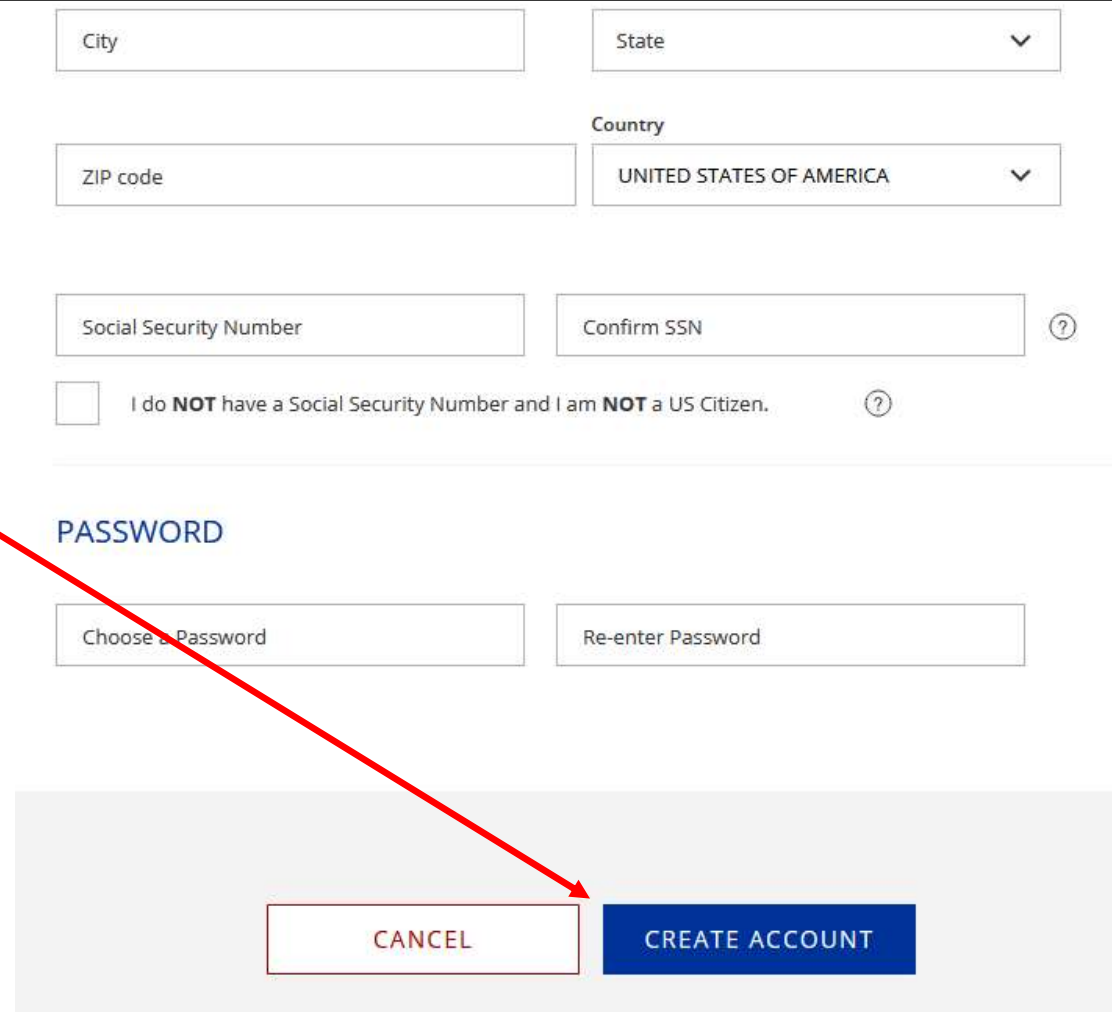
CANCEL

CREATE ACCOUNT



# Claimant Registration

Immediately after the employee clicks on *CREATE ACCOUNT*, they will receive an email from ECOMP. They must click the link within the email to complete their registration and verify their identity with a two-step authentication process.



The screenshot shows a registration form with the following fields and options:

- City** (text input)
- State** (dropdown menu)
- ZIP code** (text input)
- Country** (dropdown menu, currently set to UNITED STATES OF AMERICA)
- Social Security Number** (text input)
- Confirm SSN** (text input)
- ☐ I do **NOT** have a Social Security Number and I am **NOT** a US Citizen.
- PASSWORD** section:
  - Choose a Password** (text input)
  - Re-enter Password** (text input)
- CANCEL** button
- CREATE ACCOUNT** button

A red arrow points from the text box on the left to the **CREATE ACCOUNT** button.



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**Sign in to  
file a CA-1,  
CA-2, CA-7,  
or CA-7a.**

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Track status of form or document

[TRACK STATUS](#)

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# Employee Dashboard



[HOME](#) / [MY DASHBOARD](#)

[MY DASHBOARD](#)

[NEW CLAIM](#)

[DOCUMENTS](#)

[HELP](#)

[KRISTIN](#)

**File a CA-1,  
CA-2, CA-7, or  
CA-7a**

## Welcome to your ECOMP Dashboard

To file a new injury/illness claim, click on the "New Claim" link above.

If you are filling a claim for COVID-19, use FORM [CA-1 COVID-19](#).

Documents upload and management may be accessed in the "Documents" link above.

Each existing injury/illness claim you have initiated can be found in the Cases tab of the table below. If you have any forms in Draft Status, they will be listed in the Draft Forms tab of the table. The Action Required tab shows if additional information is required in order to process your claim. This includes returned claim forms. If you do not respond, your entitlement to benefits may be delayed or suspended. If your Action Required tab is empty there is nothing required of you at this time.

By clicking anywhere in the row of an injury/illness claim in the table below, you will be taken to its Case Review page where you can:

- Finish filing any injury/illness claims that are in Draft status.
- View case details including the injury claim information; forms associated with the case; claim status; compensation payment tracking; compensation payment history; and from within the payment period details you may also access the compensation amount, health benefit and life insurance details, payee information, and the formula for compensation. You can also access additional billing information through the "Bill Pay Inquiry" link. Pharmacy information is available through the "Pharmacy Benefit" link.
- File associated claim forms, such as a CA-7 Claim for Compensation, using the "New Case Form" drop down button within the Forms tab of the Case Review page.
- Review and respond to case letters and requests for information. If OWCP needs information to process your claim, the request letter will appear in the Response Required tab. If the request is overdue it will appear in the Overdue Request tab. If you do not respond to these items, your entitlement to benefits may be delayed or suspended. Letters that are informative and require no response appear in the Informational Letters tab.

# Employee Dashboard – Filing a Form



## Which Forms Can I File?

Each agency determines which forms are available for filing through ECOMP. The way you report an incident or file a claim depends on your employment status and your employing agency. To learn which forms you can file, fill out the information below.

### EMPLOYMENT STATUS ?

Federal Employee

Contractor

### GOVERNMENT ORGANIZATION ?

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

Select Department



**Enter the  
United States  
Postal Service**

# Employee Dashboard – Filing a Form



## GOVERNMENT ORGANIZATION ?

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

Select Department

UNITED STATES POSTAL SERVICE



**Filter by state**

Filter by State (optional)

Select a value



AK

AL

AR

AZ

CA

! Agency Group is required



Fill out the fields above. What if I don't know my government organization?



**ECOMP will determine the  
"Agency Group"**

# Employee Dashboard – Filing a Form



Select Department

UNITED STATES POSTAL SERVICE

Agency Group

ATLANTIC AREA

Select Agency

APPALACHIAN DISTRICT

NORTHERN VIRGINIA DISTRICT

RICHMOND DISTRICT

EXIT

**Select the  
correct  
district**

**Choosing the wrong  
district will cause delays  
in submission of the  
form to OWCP**



# Employee Dashboard – Filing a Form



Select Agency

RICHMOND DISTRICT

Duty Station

INJURY COMPENSATION OFFICE, 1801 BROOK ROAD, RICHMOND, VA 23232

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 filing a claim for COVID-19, use FORM CA-1 COVID-19.

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

ECOMP will auto populate the injury compensation office

Select which form to file

# Employee Dashboard – Filing a Form



## About Forms CA-1, CA-2 and CA-1 COVID-19

### WHICH FORMS SHOULD I USE?

Form **CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occurring during one work shift.

Form **CA-2 (Notice of Occupational Disease and Claim for Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occurring over more than one work shift.

Form **CA-1 COVID-19** is for use by Federal employees who were exposed to other people in the work setting and contracted COVID-19. COVID-19 is caused by the SARS-CoV-2 virus, a kind of coronavirus.

### HOW DO I FILE THE FORM?

The process for filing a form involves completing several form sections made up of smaller form-filing steps. These individual steps can be viewed in the progress bar at the top of the page.

If you filed an **OSHA-301**, the information you entered in that form will be used to automatically fill in matching fields on the FECA form, but you should edit any of the narrative responses as needed.

The form may be saved at any time and completed later. Once the form has been submitted, it will be reviewed by the employee's supervisor and/or the Agency Reviewer before submission to OWCP (if appropriate).

Select "FILE  
A CLAIM"

FILE A CLAIM



# Employee Dashboard – Filing a Form



## Select Form

You may file three types of FECA claims: CA-1, CA-2 or CA-1 COVID-19. Only one claim may be filed based on a single incident. If your agency requires a Form OSHA-301 prior to filing a FECA claim, this means that only one FECA claim form may be filed per OSHA-301.

Select the appropriate form:

CA-1 COVID-19	For COVID-19
Use this form if you were exposed to other people in the work setting and contracted COVID-19. COVID-19 is caused by the SARS-CoV-2 virus, a kind of coronavirus.	
Do not use this form if you have any other forms of traumatic injury or illness. Instead use CA-1 or CA-2 below.	
<a href="#">SELECT CA-1 COVID-19</a>	

CA-1	For Traumatic Injury
CA-1 - Federal Employee's Notice of Traumatic Injury & Claim for Continuation of Pay/Compensation	
Use this form if you have sustained a traumatic injury on the job. A traumatic injury is a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift.	
Examples of a traumatic injury include: a dog bite, a motor vehicle accident or a slip and fall.	
<a href="#">SELECT CA-1</a>	

CA-2	For Illness
CA-2 - Notice of Occupational Disease and Claim for Compensation	
Use this form if you have sustained an occupational disease as a result of your job duties. An occupational disease or illness is a condition produced by the work environment over a period longer than a single workday or shift.	
Examples of an occupational disease include: noise induced hearing loss, asbestos-related illness or orthopedic injuries due to repetitive motion.	
<a href="#">SELECT CA-2</a>	

**Select the  
type of claim**

# Employee Dashboard – Filing a Form



- 1 BASICS
- 2 INJURY
- 3 WITNESS
- 4 ATTACHMENTS
- 5 REVIEW
- 6 SIGN

## CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Welcome to CA-1. The steps in this form are listed in the navigator above. Unless otherwise noted, you must complete all fields. Start by filling out your basic information below.

### EMPLOYEE BASICS

1	Employee First Name Injured	Middle Name (optional)	Last Name Worker
1a	Employee Email injuredworker.ecomp@outlook.com		
2	Social Security Number ●●●-●●-●●●●	Confirm SSN ●●●-●●-●●●●	
3	Date of Birth 06/06/1975		
4	Sex Male Female		
5	Home Telephone (202) 555-1234	<input type="checkbox"/> International	
6	Grade as of Date of Injury 9	Step as of Date of Injury 5	

### HOME MAILING ADDRESS

7	Address 123 A St		
	City Washington	State DC - District Of Columbia	
	ZIP code 20010	Country UNITED STATES OF AMERICA	

### 8 DEPENDENTS ?

<input type="checkbox"/>	Wife, Husband
<input type="checkbox"/>	Children Under 18 Years
<input type="checkbox"/>	Other
<input checked="" type="checkbox"/>	None

### WHO SHOULD REVIEW THIS FORM? ?

Immediate Supervisor's Email sue.supervisor	Select Email Domain @dol.gov
------------------------------------------------	---------------------------------

# Claimant Registration



WHO SHOULD REVIEW THIS FORM? ?

Immediate Supervisor's Email

Select Email Domain

(ex. @dol.gov)



A supervisor or manager's email is necessary to file a form. Usually, the email is the [firstname.lastname@usps.gov](mailto:firstname.lastname@usps.gov). Any errors are referred to the local HRM office, and they should direct the form to the correct supervisor or manager.

Autosaved

EXIT



# Employee Dashboard – Filing a Form



- ✓ BASICS
- 2 INJURY
- 3 WITNESS
- 4 ATTACHMENTS
- 5 REVIEW
- 6 SIGN

## CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Describe the details of employee's injury.

### DESCRIPTION OF INJURY

Place where event occurred

9 FPB Building

3rd Floor

Address

200 C Street

City

Washington

State

DC - District Of Columbia

ZIP code

20010

Country

UNITED STATES OF AMERICA

### DATE

Date Injury Occurred

10 04/01/2019

Time Injury Occurred

10:00 am

11 Date of this Notice

If you submit this form today, it will be filed on 04/08/2019.

12 Employee's Occupation

### INJURY

The next two fields have been defaulted from the OSHA-301 form, if present. Please edit if necessary.

Cause of Injury (Describe what happened and why)

13 Lifting a box of files I strained my back

(469 characters remaining)

Nature of Injury (Identify both the injury and the part of the body, e.g. fracture of the left leg)

14 Low back strain

(235 characters remaining)

# Employee Dashboard – Filing a Form



## CA-1 Traumatic Injury Claim

ECN 119488 | Draft

**\* This step is optional.** You can attach supporting documents to this claim now, or submit them at a later date through ECOMP once a claim number has been assigned. Examples of supporting documents include witness statements, job descriptions, and medical documentation.

**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 10 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



**Step 4: Allows the injured worker to submit supporting documents with the form.**

# Employee Dashboard – Filing a Form



Progress bar: BASICS (1) INJURY (2) WITNESS (3) ATTACHMENTS (4) **REVIEW (5)** SIGN (6)

## CA-1 Traumatic Injury Claim

ECN 119488 | Draft

### EMPLOYEE BASICS

[Edit](#)

1 Employee First Name Middle Name Last Name  
Injured

1a Employee Email  
injuredworker.ecomp@outlook.com

Government Organization  
XX ECOMP TEST (DO NOT USE)  
OFFICE OF ECOMP TESTING  
C/O ECOMP - XX TEST  
203 UNION STREET, WASHINGTON, DC, 20210

2 Social Security Number  
●●●●●●●●

3 Date of Birth  
06/06/1975

4 Sex  
Male

5 Home Telephone  
(202) 555-1234

6 Grade as of Date of Injury Step as of Date of Injury  
9 5

12 Employee's Occupation  
Claims Examiner [Edit](#)

### INJURY

[Edit](#)

13 Cause of Injury  
Lifting a box of files I strained my back

14 Nature of Injury  
Low back strain

### WITNESS

[Edit](#)

16 Witness First Name Middle Name Last Name  
NO RESPONSE GIVEN NO RESPONSE GIVEN

Address  
NO RESPONSE GIVEN

Date of Witness Statement  
NO RESPONSE GIVEN

### ATTACHMENTS

[Add/Modify Attachments](#)

DCN 119489  
Type: General Inquiry (Non-Medical) | Authored Date: 04/03/2019  
Submitted by injuredworker.ecomp@outlook.com on 04/08/2019 at 3:44 PM

[View](#)

**Always review  
for accuracy**

**DCN # is verification of  
document upload**



# Employee Dashboard – Filing a Form



## CA-1 Traumatic Injury Claim

ECN 119488 | 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

**Advise injured worker to select COP**

# Employee Dashboard – Filing a Form

## CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Attention

**I understand that** any person who knowingly makes any false statements, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is entitled is subject to civil or administrative remedies as well as **felony criminal prosecution** and may, under appropriate criminal provisions, be **punished by a fine or imprisonment or both.**

In addition, a felony conviction will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.



EXIT

SIGN AND FILE






# Employee Dashboard – Filing a Form

This form has been forwarded for review.

## CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

 FORM LOCKED	<b>ECN 119488</b> CA-1	<b>Pending Review by Supervisor</b>	
	Employee Injured Worker Organization OFFICE OF ECOMP TESTING	Date of Event Initiated	04/01/2019 04/08/2019
<a href="#">View</a> <a href="#">Upload Attachments</a> <a href="#">Get PDF</a>			

- An email has been sent to your supervisor's email account at [sue.supervisor@dol.gov](mailto:sue.supervisor@dol.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.

The Electronic Control Number (ECN) verifies the form submission

After submission, the supervisor will receive an email to complete the form

DONE



# CA-16 – NO EXCUSES

- Designed to allow an injured worker to choose their own physician (ELM 543.3)
- Should go to the injured employee

## Authorization for Examination And/Or Treatment

U.S. Department of Labor  
Office of Workers' Compensation Programs



The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. 130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. NOTE: THIS FORM IS NOT TO BE REPRODUCED OR DUPLICATED (See Instructions). IF INSTRUCTIONS ARE SEPARATED FROM THIS FORM, REFER TO FORM INFORMATION <https://www.dol/owcp/dfec>

OMB No.: 1240-0046  
Expires: 03-31-2021

### PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service within the meaning of FECA (See Instructions for definition of a qualified physician):

2. Employee's Identification (last, first, middle, SSN)

3. Date of Injury (mo., day, yr.)

4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2 item

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services. PLEASE NOTE THIS AUTHORIZATION DOES NOT INCLUDE PRESCRIPTIONS FOR COMPOUND MEDICATIONS OR PHYSICIAN DISPENSED MEDICATION. SEE INSTRUCTIONS FOR ADDITIONAL MEDICAL INFORMATION.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from (Type Name and Title of OWCP Official)

8. Name and Address of Employee's Place of Employment

Department or Agency:

Bureau or Office:

Local Address (Including Zip Code)

9. Local Employing Agency Telephone Number (Including Area Code):

10. Name and Title of Authorized Official (Type or Print Clearly): (See Instructions)

11. Send one copy of your report to:

U.S. DEPARTMENT OF LABOR  
DFEC CENTRAL MAILROOM  
P.O. BOX 8300

SAMPLE



# Agency Reviewer Dashboard – HRM

HRM reviews  
the form after  
the supervisor.

## CA-1 Traumatic Injury Claim

ECN 119488 | Pending Final Review by FECA Agency Reviewer

 FORM LOCKED	ECN 119488   CA-1		<i>Pending Final Review by FECA Agency Reviewer</i>	
	Employee Organization	Injured Worker OFFICE OF ECOMP TESTING	Date of Event Initiated	04/01/2019 04/08/2019
			<a href="#">View</a>	<a href="#">Get PDF</a>

- You can print a copy of this form using the 'Get PDF' button above.
- A digital copy of this form will be kept by ECOMP for 5 years. (Public Law 91-596 and 29 CFR 1904)

**NO EXCUSES**  
for failing to  
provide  
CA-16 (ELM

ISSUE CA-16

DONE

