GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

Form CA10 REQUEST FOR LEAVE RESTORATION

Use this form to request restoration of leave charged as a result of an accepted disability arising out of a work-related injury. ***Once approved, prior to restoration, Claimant must agree to pay the difference between 66 2/3% (75% if the claimant is entitled to augmented pay) and 100% of the value of the leave.***

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE
For Help and Information, call (202) 442-HELP (4357)

FOR DISABILITY LASTING 21 DAYS or LESS: SUBMIT FORM TO YOUR EMPLOYING AGENCY Human Resources Advisor within **fourteen (14)** calendar days of approval of Continuation of Pay (COP), if the disability does not exceed twenty-one (21) days.

FOR DISABILITY LASTING 21 DAYS or MORE: SUBMIT FORM TO THE PUBLIC SECTOR WORKERS' COMPENSATION PROGRAM (PSWCP) within fourteen (14) calendar days of acceptance of the claim for indemnity benefits.

CLAIMANT INFORMATION

Claimant's Name: _____
Claimant's Full Address (with unit number, zip code):

Employing Agency: _____
Supervisor name: _____

Claimant's Telephone: _____
Claimant's E-mail: _____
Claim Number: _____
Claim Accepted Date: _____

Date of Injury, Disability or Recurrence: _____
Date of COP Acceptance: _____
Date PSWCP Disability Compensation Began: _____

LEAVE RESTORATION

Did disability exceed fourteen (14) days? ☐ Yes ☐ No

Does Claimant have a permanent disability? ☐ Yes ☐ No

Select type of leave to be restored:

☐ ANNUAL LEAVE Total Hours Taken: _____ Hours to be restored: _____

Period(s) leave used:

_____

☐ SICK LEAVE Total Hours Taken: _____ Hours to be restored: _____

Period(s) leave used:

_____

☐ OTHER PAID LEAVE *Identify other paid leave*: _____

NOTE: *Other paid leave may include compensatory time or administrative leave given as an incentive award. Paid holiday leave is excluded from restoration. Restoration of paid leave that is neither annual leave nor sick leave is subject to approval of the Employing Agency, Payroll and/or the PSWCP.*

Total Hours Taken: _____ Hours to be restored: _____

Period(s) leave used:

_____

I have read this Request Form and I swear or affirm that the contents are true and accurate to the best of my knowledge.

CLAIMANT'S SIGNATURE: _____ **DATE:** _____

Claimant **MUST** file this form by mail, e-mail, or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 8:30 a.m. and 5:00 p.m. You will need photo ID to enter the building.	**Office of Risk Management** **One Judiciary Square** **441 Fourth Street, N.W., Suite 800 South** **Washington, DC 20001-2714** **Phone: (202) 442-HELP (4357)** **Email: wcsecure@dc.gov**