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: ___________________________  Employing Agency: ___________________________
Claimant’s Full Address (with unit number, zip code): ___________________________

Claimant’s Telephone: ___________________________  Date of Injury, Disability or Recurrence: ___________________________
Claimant’s E-mail: ___________________________  Date of COP Acceptance: ___________________________
Claim Number: ___________________________  Date PSWCP Disability Compensation Began: ___________________________
Claim Accepted Date: ___________________________
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
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