

# Duty Status Report

# U.S. Department of Labor

Employment Standards Administration  
Office of Workers' Compensation Programs



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0103  
Expires: 09-30-2011

OWCP File Number  
(If known)

**SIDE A - Supervisor:** Complete this side and refer to physician **SIDE B - Physician:** Complete this side

1. Employee's Name (Last, first, middle)		8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, describe)	
2. Date of Injury (Month, day, yr.)	3. Social Security No.	9. Description of Clinical Findings	
4. Occupation			
5. Describe How the Injury Occurred and State Parts of the Body Affected		10. Diagnosis Due to Injury	
6. The Employee Works Hours Per Day _____ Days Per Week _____		11. Other Disabling Conditions	
7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or intermittently, and Give Number of Hours.		12. Employee Advised to Resume Work? <input type="checkbox"/> Yes, Date Advised ____/____/____ <input type="checkbox"/> No	
13. Employee Able to Perform Regular Work Described on Side A? <input type="checkbox"/> Yes, If so <input type="checkbox"/> Full-Time or <input type="checkbox"/> Part-Time _____ Hrs Per Day <input type="checkbox"/> No, If not, complete below:			

Activity	Continuous		Intermittent	Continuous		Intermittent
	#lbs.	#lbs.		#lbs.	#lbs.	
a. Lifting/Carrying: State Max Wt.			Hrs Per Day			Hrs Per Day
b. Sitting			Hrs Per Day			Hrs Per Day
c. Standing			Hrs Per Day			Hrs Per Day
d. Walking			Hrs Per Day			Hrs Per Day
e. Climbing			Hrs Per Day			Hrs Per Day
f. Kneeling			Hrs Per Day			Hrs Per Day
g. Bending/Stooping			Hrs Per Day			Hrs Per Day
h. Twisting			Hrs Per Day			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day			Hrs Per Day
j. Simple Grasping			Hrs Per Day			Hrs Per Day
k. Fine Manipulation (includes keyboarding)			Hrs Per Day			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day			Hrs Per Day
o. Temp. Extremes			range in degrees F			range in degrees F
p. High Humidity			Hrs Per Day			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day			Hrs Per Day
r. Fumes/Dust (identify)			Hrs Per Day			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day			dBA Hrs Per Day

t. Other (Describe)	14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe)	
	15. Date of Examination	16. Date of Next Appointment
	17. Specialty	18. Tax Identification Number
	19. Physician's Signature	20. Date

**INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)**

**SUPERVISOR:** Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

**PHYSICIAN:** Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

**Medical Facility Name and Address**

**Send Original Report to:**

**Employing Agency Address**

**Send a Copy of This Report to:**

**OFFICE OF WORKERS' COMPENSATION PROGRAMS**

**CERTIFICATION:** BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

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**Public Burden Statement**

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the OWCP, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**