OWCP Medical / Therapy Visit

Patient Name _____

OWCP Claim # _____

Date of Injury ___/___/_____

The above named patient was in my office for evaluation and/or treatment of a work-related injury.

Date of Visit: ___/___/_____

Time In: _____

Time Out: _____

Next Visit Date and Time: ___/___/_____ ____:_____am / pm

_____

Doctor / Therapist Signature

- Attach this form to all Claims for Compensation (CA-7 / CA-7a)
- Also attach CA-17, CA-20, and Disability Narrative Signed by the Treating Doctor
- Claims for Compensation should be submitted to OWCP every 2 weeks.

Not an official OWCP Form