U.S. DEPARTMENT OF LABOR Bureau of Employees' Compensation	EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE (Under the Federal Employee's Compensation Act)

The immediate superior whould complete the reverse side of this form.

1. Name of Injured Employee (Last, first, middle)	2. Date of this Notice(mo,day,yr)
3. Place of Employment (Name & Location)	4. Date of Injury (mo,day,yr)
5. Occupation	6. Hour of Injury (AM or PM)

7. Place or Location Where Injury Occurred

8. Cause of Injury (Describe how and why injury occurred)

9. Nature of Injury (Name of body affected-fractured left leg, bruised thumb, etc.)

10. Names of Witnesses to Injury

11. If this Notice was not given within 48 hours after injury, explain reason for delay. If earlier notice was given, verbal or written, state when and to whom.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.	12. Signature 13. Home address of Injured Employee

Form CA-1

STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit a statement and secure statements of witnesses where possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. Date CA-1 received by Agency (mo. day, yr.)	15. CA-1 Received by whom

16. Statement of immediate superior

17. Signature of immediate superior	18. Date (mo, day, yr.)

19. Statement of Witness

20. Signature of witness	21. Date (mo, day, yr.)

22. Statement of Witness

23. Signature of Witness	24. Date (mo, day, yr.)