OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department NAVY (Army, Navy, etc.) 2. Bureau or office MSTSPAC (Engineer, Navigation, etc.)
3. Place of employment Naval Supply Center (Arsenal, navy yard, etc.), Oakland (City), California 94625 (State)
4. Reporting office USN S GENERAL JOHN POPE, T AP 110 (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred

The injured employee

6. Name of injured employee James W. Fisher 32265 (Give last name in full) 7. Age 57 8. Sex M 9. Citizenship USA
10. Home address ——— (Street and number), ——— (City or town), ——— (State)
11. Occupation and division FWT (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? yes If not, what work?
13. Total length of service with the Government as a civilian? 2 years
14. How long at present work in this establishment? 1 year
15. Dates of other injuries Unknown
16. Rate of pay on date of injury, $ 5034.00 per annum { and subsistence valued at $ 421.20 per annum; and quarters valued at $ 126.00 per annum
17. Employee begins work at 0000-0400 (Hour, a. m. or p. m.) m. 18. Regular day's work ends 1200-1600 (Hour, a. m. or p. m.) m.
19. Hours worked per day 8 20. Days paid per week 7

The injury

21. Place where injury occurred FSD Hatch, After Engine Room (Give exact location, as name or number of building and division, etc.)
22. Date of injury 20 May, 19 68; day of week Monday; hour of day 2330 (a. m. or p. m.) m.
23. Date employee stopped work No, 19 ; day of week ; hour of day (a. m. or p. m.) m.
24. Date employee's pay stopped No, 19 ; day of week ; hour of day (a. m. or p. m.) m.
25. Has employee returned to work? yes 1200, 5/21/68 (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave No (Give exact dates)
(b) Sick leave No (Give exact dates)
(c) Any other reason No (Give exact dates)
27. Describe in full how injury occurred right foot
Door closed on patient foot, causing swelling and pain.
Accident happened as stated in paragraph 5 Navexos 108, (Rev. 1-60)
28. State part of body injured and nature and extent of injury
Arch of right foot swollen. Right Contusion
29. Did injury cause loss of any member or part of member? No If so, describe exactly
30. Was employee injured while in performance of duty? yes If not, or in doubt, give detailed statement
31. Was injury caused by:
(a) Willful misconduct of the employee? No (b) Intention of employee to bring about injury or death of himself or another? No (c) Employee's intoxication? No
(If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? yes If not, did immediate superior have actual knowledge of injury?
(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury
None
(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? No If so, has employee been instructed in procedure under the Bureau's regulations?
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case J. Westcott Lorenz M.D.
36. How soon after injury? about 2 hours
37. To what hospital sent? Stupa Hospital Location USS Pope
38. Name and address of physician now attending case Navy

Signed this 24th day of May, 1968
at USS Pope
(Signature of reporting officer)
Chief Engr
(Title)

C. A. 2
December 1961

(OVER)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

Signed this _____ day of _____, 19_____

_____
(Signature of witness)

Signed this _____ day of _____, 19_____

_____
(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ was given first-aid treatment, or examined,
(Name of employee)
on _____, 19_____, at _____ m., and _____ disabled for work. Probable length of
(Was or was not)
disability will be _____ In my opinion disability _____ due to injury
(Was or was not)
on _____, 19_____

Nature of injury as found on examination _____

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19_____

at _____

_____
(Signature of medical officer)

_____
(Title)

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