

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.]

	1. Department <u>NAVY</u> <small>(Army, Navy, etc.)</small>	2. Bureau or office <u>ENGINEERING</u> <small>(Engineer, Navigation, etc.)</small>
Place of employment	3. Place of employment <u>USNS GENERAL JOHN POPE, T AP 110</u> <small>(Arsenal, navy yard, etc.)</small>	4. Reporting office <u>USNS GENERAL JOHN POPE, T AP 110</u> <small>(City) (State)</small>
	5. Name of superintendent or foreman in charge when injury occurred _____	
The injured employee	6. Name of injured employee <u>Robert H. JOHNSON</u>	7. Age _____
	8. Sex <u>M</u>	9. Citizenship <u>USA</u>
	10. Home address _____ <small>(Street and number) (City or town) (State)</small>	
	11. Occupation and division <u>Winer, Engine Department</u> <small>(Give both, as laborer, hull division; helper, machine shop, etc.)</small>	
	12. Was employee doing his regular work? <u>yes</u> If not, what work? _____	
	13. Total length of service with the Government as a civilian? <u>5-66 age 47</u>	
	14. How long at present work in this establishment? <u>Assigned 3-19-68</u>	
	15. Dates of other injuries <u>Unknown</u>	
	16. Rate of pay on date of injury, \$ <u>4986.00</u> per annum { and subsistence valued at \$ <u>421.20</u> per annum and quarters valued at \$ <u>126.00</u> per annum	
	17. Employee begins work at <u>0800</u> m. 18. Regular day's work ends <u>1700</u> m. <small>(Hour, a. m. or p. m.) (Hour, a. m. or p. m.)</small>	
19. Hours worked per day <u>8</u> 20. Days paid per week <u>7</u>		
The injury	21. Place where injury occurred <u>#1 Fan Room, fr. 02-106-0-E</u> <small>(Give exact location, as name or number of building and division, etc.)</small>	
	22. Date of injury <u>11 April 1968</u> ; day of week <u>Thursday</u> ; hour of day <u>1045</u> m. <small>(a. m. or p. m.)</small>	
	23. Date employee stopped work <u>11 April 1968</u> ; day of week <u>Thursday</u> ; hour of day <u>1045</u> m. <small>(a. m. or p. m.)</small>	
	24. Date employee's pay stopped <u>No</u> , 19____; day of week _____; hour of day _____ m. <small>(a. m. or p. m.)</small>	
	25. Has employee returned to work? <u>yes</u> , <u>2800, 4/15/68</u> <small>(Give date and hour)</small>	
	26. Will employee receive pay for any portion of above absence on account of: (a) Annual leave _____ (b) Sick leave <u>1200, 4/11/68 to 1400, 4/12/68</u> <small>(Give exact dates)</small> (c) Any other reason _____ <small>(Give exact dates)</small>	
	27. Describe in full how injury occurred _____ <u>Employee was removing air filters from vent in Fan Room #1, Fr. 02-106-0-E, and while doing so, filters dropped suddenly on his right temple, causing laceration.</u>	
	28. State part of body injured and nature and extent of injury _____ <u>Right temple, laceration Small laceration</u>	
	29. Did injury cause loss of any member or part of member? <u>No</u> If so, describe exactly _____	
	30. Was employee injured while in performance of duty? <u>YES</u> If not, or in doubt, give detailed statement _____	
	31. Was injury caused by: (a) Willful misconduct of the employee? <u>No</u> (b) Intention of employee to bring about injury or death of himself or another? <u>No</u> (c) Employee's intoxication? <u>No</u> <small>(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)</small>	
	32. Was written notice of injury given within 48 hours? <u>YES</u> If not, did immediate superior have actual knowledge of injury? _____ <small>(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)</small>	
	33. Names and addresses of witnesses to injury _____ <u>None</u>	
	34. Was injury caused by a third party other than a Government employee or agency? <u>No</u> If so, has employee been instructed in procedure under the Bureau's regulations? _____ <small>(A detailed statement should be forwarded with this report)</small>	
	Medical attendance	35. Name and address of physician who first attended case <u>Med. Clinic, NSC Oakland, CA</u>
36. How soon after injury? <u>immediately</u>		
37. To what hospital sent? <u>USNS General John Pope TAP 110</u> Location <u>USNS General John Pope TAP 110</u>		
38. Name and address of physician now attending case <u>None</u>		
Signed this <u>12th</u> day of <u>April</u> , 19 <u>68</u> <u>M S CHAMBERLAIN</u> at <u>USNS GENERAL JOHN POPE, T AP 110</u> <u>Chief Engineer</u> <small>(Signature of reporting officer) (Title)</small>		

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)