

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	2. Bureau or office STS VSC OAKLAND CA	3. Place of employment USNS GENERAL JOHN POPE, T AP 110	4. Reporting office USNS GENERAL JOHN POPE, T AP 110	5. Name of superintendent or foreman in charge when injury occurred
	(Army, Navy, etc.)		(Arsenal, navy yard, etc.)		(City) (State)
The injured employee	6. Name of injured employee Robert R. JOHNSON	7. Age 56	8. Sex M	9. Citizenship USA	
	10. Home address	(Street and number)		(City or town)	(State)
	11. Occupation and division	Winer, Engine Department		12. Was employee doing his regular work? yes If not, what work?	
	13. Total length of service with the Government as a civilian?	5-66 age - 47			
	14. How long at present work in this establishment?	Assigned 3-19-68			
	15. Dates of other injuries	Unknown			
	16. Rate of pay on date of injury, \$ 4986.00	per annum	and subsistence valued at \$ 421.20 per annum		
			and quarters valued at \$ 126.00 per annum		
	17. Employee begins work at 0800	m.	18. Regular day's work ends 1700	m.	(Hour, a. m. or p. m.) (Hour, a. m. or p. m.)
19. Hours worked per day 8		20. Days paid per week 7			
21. Place where injury occurred #1 Fan Room, fr. 02-106-0-E	(Give exact location, as name or number of building and division, etc.)				
22. Date of injury 11 April 1968	, 19	day of week Thursday	hour of day 1045	m.	
23. Date employee stopped work 11 April 1968	, 19	day of week Thursday	hour of day 1045	m.	
24. Date employee's pay stopped No	, 19	day of week	hour of day	m.	
25. Has employee returned to work? yes, 200, 4/15/68	(Give date and hour)				
26. Will employee receive pay for any portion of above absence on account of:					
(a) Annual leave	1200, 4/11/68 to 1200, 4/15/68				
(b) Sick leave	(Give exact dates)				
(c) Any other reason	(Give exact dates)				
27. Describe in full how injury occurred	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 facial laceration.				
28. State part of body injured and nature and extent of injury	Right temple, laceration Small laceration				
The injury	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	Med.Clinic, NSC Oakland, CA			
	36. How soon after injury?	immediately			
	37. To what hospital sent?	USNS GENERAL JOHN POPE, T AP 110	Location	NSC Oakland, CA	
	38. Name and address of physician now attending case	None			

Signed this **12th** day of **April**, 19**68**
at **USNS GENERAL JOHN POPE, T AP 110**

M S CHAMBERLAIN
(Signature of reporting officer)
Chief Engineer
(Title)

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
disability will be _____ In my opinion disability _____ due to injury
(Was or was not)
on _____, 19_____.
(Was or was not)

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)