

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.]

	NAVY	M.S.T.S.
Place of employment	1. Department _____	2. Bureau or office _____
	(Army, USNS GEN. J. POPE (T-AP113))	(Engineer, Navigation, etc.)
	3. Place of employment _____	(Arsenal, navy yard, etc.) NSC OAKLAND, CALIF.
	4. Reporting office _____	(Location of reporting office or division headquarters) HIGGERS, JAMES
5. Name of superintendent or foreman in charge when injury occurred		
6. Name of injured employee PETER J. ARCURI <small>first name in full)</small>		7. Age 23 8. Sex M 9. Citizenship U.S.
10. Home address _____		
11. Occupation and division WIPER (ENGINE DEPT.). <small>(Give both, as laborer, hull division; helper, machine shop, etc.)</small>		
12. Was employee doing his regular work? YES If not, what work? _____		
13. Total length of service with the Government as a civilian? 1 MONTH		
14. How long at present work in this establishment? 16 DECEMBER 1966		
15. Dates of other injuries _____		
16. Rate of pay on date of injury, \$ _____ per _____ <small>and subsistence valued at \$ _____ per _____ and quarters valued at \$ _____ per _____</small>		
17. Employee begins work at 0600 a.m. 18. Regular day's work ends 1730 p.m. <small>(Hour, a. m. or p. m.)</small>		
19. Hours worked per day 8 HRS. 20. Days paid per week 7 DAYS		
21. Place where injury occurred USNS GEN. J. POPE (T-AP113), COOL ROOM OVER PEEPER FLAT. <small>(Give exact location, as name or number of building and division, etc.)</small>		
22. Date of injury 16 DECEMBER 66 , 19 _____; day of week FRIDAY ; hour of day 2130 p.m. <small>(a. m. or p. m.)</small>		
23. Date employee stopped work 1730 , 19 _____; day of week _____; hour of day _____ m. <small>(a. m. or p. m.)</small>		
24. Date employee's pay stopped _____, 19 _____; day of week _____; hour of day _____ m. <small>(a. m. or p. m.)</small>		
25. Has employee returned to work? YES <small>(Give date and hour)</small>		
26. Will employee receive pay for any portion of above absence on account of: YES (a) Annual leave NONE <small>(Give exact dates)</small> (b) Sick leave NONE <small>(Give exact dates)</small> (c) Any other reason NONE <small>(Give exact dates)</small>		
27. Describe in full how injury occurred EMPLOYEE STRAINED HIS BACK AS HE WAS MOVING A DISCONNECTED EVAPORATOR STRAINER ALONG THE DECK FOR THE PURPOSE OF STOWAGE.		
28. State part of body injured and nature and extent of injury BACK		
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 NO of himself or another? NO (c) Employee's intoxication? NO <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? YES 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 JAMES HIGGERS,		
----- <small>(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)</small>		
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? _____ <small>(A detailed statement should be forwarded with this report)</small>		
35. Name and address of physician who first attended case S.P. EDWARDS LT MC USNR. USNS POPE		
Medical attendance	36. How soon after injury? _____	
	37. To what hospital sent? DISPENSARY	
	38. Name and address of physician now attending case _____	

Signed this **21** day of **DECEMBER**, 19 **66**
at **USNS GEN. J. POPE (T-AP113)**

C. A. 2
December 1961

B. C. QUINN
(Signature of reporting officer)

CHIEF ENGINEER

(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 PETER JOHN ARCURI was given first-aid treatment, or examined, on 16 DECEMBER, 1966 ^(Name of employee) at 8:00 a.m., and was not ^(Was or was not) disabled for work. Probable length of disability will be None ^(Was or was not) In my opinion disability not ^(Was or was not) due to injury on 16 DECEMBER, 19 66

Nature of injury as found on examination was completely within normal limits. No evidence of injury was noted

Hospitalized No Will return for further treatment No

Discharged No Other disposition No other.

Remarks Concur with above examination.

Signed this 22 day of DECEMBER, 19 66
at USNS GEN. J. POPE (T-AP110)

Samuel R. Edwards
SAMUEL R. EDWARDS
(Signature of medical officer)
LT (MC) USNSR (SMO)
(Title)