

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 Nav. T. S.
(Army, Navy, etc.) (Engineer, Navigation, etc.)
3. Place of employment USNS GEN. POPE (T-115)
(Arsenal, navy yard, etc.) (City) (State)
4. Reporting office H. C. C. LAND, CALIFORNIA
(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 MAXIM, C. BEARDS 7. Age 47 8. Sex M 9. Citizenship U.S.
(Give first name in full)
10. Home address _____
(Street and number) (City or town) (State)
11. Occupation and division 2ND ELECTRICIAN (D.A.) 12. Was employee doing his regular
(Give both, as laborer, hull division; helper, machine shop, etc.) work? YES If not, what work? _____
13. Total length of service with the Government as a civilian? 1 YEAR
14. How long at present work in this establishment? 1 YEAR
15. Dates of other injuries _____
16. Rate of pay on date of injury, \$7.128 per YEAR { and subsistence valued at \$ 1.17 per DAY
and quarters valued at \$.35 per DAY
17. Employee begins work at 1300 a. m. 18. Regular day's work ends 1720 p. m.
(Hour, a. m. or p. m.) (Hour, a. m. or p. m.)
19. Hours worked per day 6 20. Days paid per week 5

21. Place where injury occurred SHIPS LAUNDRY - USNS GEN. JOHN POPE
(Give exact location, as name or number of building and division, etc.)
22. Date of injury SEPT. 27, 1966; day of week TUESDAY; hour of day 810 a. m.
(a. m. or p. m.)
23. Date employee stopped work _____, 19____; day of week _____; hour of day _____ m.
(a. m. or p. m.)
24. Date employee's pay stopped _____, 19____; day of week _____; hour of day _____ m.
(a. m. or p. m.)
25. Has employee returned to work? _____
(Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave _____
(b) Sick leave _____
(c) Any other reason _____
(Give exact dates)
27. Describe in full how injury occurred Employee got some oil on his hand while he was working on Electric Equipment in Laundry. He rubbed his eye and got oil in it, which was irritating to his eye.

The injury

28. State part of body injured and nature and extent of injury _____
29. Did injury cause loss of any member or part of member? _____ 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 _____

Medical
attendance

34. Was injury caused by a third party other than a Government employee or agency? _____ If so, has employee been instructed in procedure under the Bureau's regulations? YES
(A detailed statement should be forwarded with this report)
35. Name and address of physician who first attended case _____
36. How soon after injury? _____
37. To what hospital sent? USNS GEN. POPE Location San Francisco (T-115)
38. Name and address of physician now attending case _____

Signed this _____ day of _____, 19____
at _____
(Signature of reporting officer)
(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
 _____ (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)