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 M S T S (Engineer, Navigation, etc.)
3. Place of employment USNS POPE (Arsenal, navy yard, etc.), , (City), (State)
4. Reporting office N.S.C. OAKLAND CALIF. (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 George Burney Jr. 7. Age 36 8. Sex M 9. Citizenship US.
10. Home address (Street and number), (City or town), (State)
11. Occupation and division 3RD ASST. ENGINEER (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? ~~8-2-58~~ 12-10-51
14. How long at present work in this establishment? 9-3-66
15. Dates of other injuries
16. Rate of pay on date of injury, $ 8,542 per ANUM { and subsistence valued at $ ~~27360~~ 42120 per ANUM; and quarters valued at $ ~~1260.00~~ per
17. Employee begins work at 0001 - ~~0400~~ 1200 m. 18. Regular day's work ends 1836 0400 - 1600 m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 20. Days paid per week 7

The injury

21. Place where injury occurred FORWARD E.R. ABOARD USNS GEN JOHN POPE (Give exact location, as name or number of building and division, etc.)
22. Date of injury , 1966; day of week 9 SEPT; hour of day 4:15 P m. (a. m. or p. m.)
23. Date employee stopped work , 1966; day of week 10 SEPT; hour of day 8:00 A. m. (a. m. or p. m.)
24. Date employee's pay stopped , 1966; day of week 10 SEPT; hour of day 8:00 A. m. (a. m. or p. m.)
25. Has employee returned to work? 1030 AM. 13 SEPT 1966 (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave
(b) Sick leave 10 SEPT 1966 TO 13 SEPT. 1966 (Give exact dates)
(c) Any other reason (Give exact dates)
27. Describe in full how injury occurred SEE #9 ON 108
28. State part of body injured and nature and extent of injury 1st & 2nd degree burn to head, face & shoulder.
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
DANIEL H. DIERS
(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
36. How soon after injury?
37. To what hospital sent? Location
38. Name and address of physician now attending case

Signed this day of , 19
at
(Signature of reporting officer)
(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.]

X DIERS STATMENT.

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