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 GEN. POPE (T-AP 110) (Arsenal, navy yard, etc.) (City) (State)
4. Reporting office NSC 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 HERMAN M. JONES (Give first name in full) 7. Age 51 8. Sex M 9. Citizenship U.S.
10. Home address (Street and number) (City or town) (State)
11. Occupation and division 2ND ENGINEER ENGR DEPT (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? 1 YEAR, 5 MONTHS
14. How long at present work in this establishment? 3 MONTHS
15. Dates of other injuries NO OTHER
16. Rate of pay on date of injury, $ per { and subsistence valued at $ per ; and quarters valued at $ per
17. Employee begins work at 0400 a.m. (Hour, a. m. or p. m.) 18. Regular day's work ends 1600-2000 p.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 USNS GEN. POPE (T-AP110) FWD. ENGINE ROOM (Give exact location, as name or number of building and division, etc.)
22. Date of injury 24 NOVEMBER, 1966; day of week THURSDAY; hour of day 5:30 p.m. (a. m. or p. m.)
23. Date employee stopped work (NA), 19; day of week ; hour of day m. (a. m. or p. m.)
24. Date employee's pay stopped (NA), 19; day of week ; hour of day m. (a. m. or p. m.)
25. Has employee returned to work? YES (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave (Give exact dates) NONE
(b) Sick leave (Give exact dates) NONE
(c) Any other reason (Give exact dates) NONE
27. Describe in full how injury occurred INJURE WAS SUSTAINED TO LEFT EYE, DUE TO CHEMICAL COMPOUND SPLASHING INTO IT (EYE) FROM THE BOILER CHEMICAL CHARGING TANKS TOP END WHEN THE VALVE WAS OPENED TO COMPLETELY FILL TANK WITH WATER PRIOR TO DISCHARGING CHEMICALS INTO THE BOILER.
28. State part of body injured and nature and extent of injury LEFT EYE
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? 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 S.R. EDWARDS LT MC USNR
36. How soon after injury?
37. To what hospital sent? USNS POPE DISPENSARY Location USNS GEN. JOHN POPE (T
38. Name and address of physician now attending case

Signed this 24 day of NOVEMBER, 19 66
at USNS GEN. POPE (T-AP110)

E. C. QUINN
(Signature of reporting officer)
CHIEF ENGINEER
(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.]

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 Herman M. JONES (Name of employee) was given first-aid treatment, or examined, on 24 NOVEMBER, 1966, at 1810 m., and not (Was or was not) disabled for work. Probable length of disability will be not applicable In my opinion disability was not (Was or was not) due to injury on 24 NOVEMBER, 1966

Nature of injury as found on examination CHEMICAL BURN, LEFT EYE (CORNEA)

Hospitalized NO Will return for further treatment YES

Discharged Other disposition FIT FOR DUTY

Remarks

Signed this 10 day of NOVEMBER, 1966

at USNH GTMO, JOHN POPE T-AP 110

Samuel R. Edwards LT MC USN

(Signature of medical officer)

(Title)

U.S. GOVERNMENT PRINTING OFFICE: 1964—O-734-915