

# 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 <b>NAVY</b> (Army, Navy, etc.)	2. Bureau or office <b>U.S.N. GEN. POPE (T-AP 113)</b> (Arsenal, navy yard, etc.)	3. M.S.T.S. (Engineer, Navigation, etc.)	
	3. Place of employment <b>U.S.N. GEN. POPE (T-AP 113)</b> (Arsenal, navy yard, etc.)	4. Reporting office <b>U.S.N. GEN. POPE (T-AP 113)</b> (Location of reporting office or division headquarters)	5. (City) (State)	
	5. Name of superintendent or foreman in charge when injury occurred			
The injured employee	6. Name of injured employee <b>BOY D. MC GINNIS</b> (Give first name in full)	7. Age <b>32</b>	8. Sex <b>M</b>	
	10. Home address <b>ROUTE 3, BOX 521</b> (Street and number)	9. Citizenship <b>U.S.</b>	11. PORT ORCHARD (City or town) <b>WASH.</b> (State)	
	11. Occupation and division <b>ENGINE UTILITY (ENG. DEPT.)</b> (Give both, as laborer, hull division; helper, machine shop, etc.)	12. Was employee doing his regular work? If not, what work?		
	13. Total length of service with the Government as a civilian?	<b>5 MONTHS</b>		
	14. How long at present work in this establishment?	<b>5 MONTHS</b>		
	15. Dates of other injuries			
	16. Rate of pay on date of injury, \$ <b>1.20</b> per	and subsistence valued at \$ <b>1.20</b> per		
		and quarters valued at \$ <b>1.20</b> per		
	17. Employee begins work at <b>7:30</b> (Hour, a. m. or p. m.)	18. Regular day's work ends <b>17:30</b> (Hour, a. m. or p. m.)		
	19. Hours worked per day <b>8 HRS.</b>	20. Days paid per week <b>7 DAYS</b>		
21. Place where injury occurred <b>U.S.N. GEN. POPE (T-AP 113), ENGINE UTILITY ROOM</b> (Give exact location, as name or number of building and division, etc.)				
22. Date of injury <b>26 NOVEMBER 1966</b>	23. Date employee stopped work <b>26 NOVEMBER 1966</b>	24. Date employee's pay stopped <b>26 NOVEMBER 1966</b>	25. Has employee returned to work? <b>YES</b> (Give date and hour)	
26. Will employee receive pay for any portion of above absence on account of: (a) Annual leave <b>NO</b> (b) Sick leave <b>NO</b> (c) Any other reason <b>NO</b>	(Give exact dates) <b>NO</b>			
27. Describe in full how injury occurred	<b>WHILE STANDING NEAR THE VENTILATION, A DUST PARTICLE FROM A VENTILATOR BLEW INTO EMPLOYEE'S EYE</b>			
28. State part of body injured and nature and extent of injury	<b>Right eye</b>			
29. Did injury cause loss of any member or part of member? <b>NO</b>	If so, describe exactly			
30. Was employee injured while in performance of duty? <b>YES</b>	If not, or in doubt, give detailed statement			
31. Was injury caused by: (a) Willful misconduct of the employee? <b>NO</b>	(b) Intention of employee to bring about injury or death of himself or another? <b>NO</b>			
	(c) Employee's intoxication? <b>NO</b>			
	(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? <b>YES</b>	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				
(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)			
35. Name and address of physician who first attended case <b>SAMUEL R. EDWARDS LT. MC USNR. (SMO)</b>				
36. How soon after injury?				
37. To what hospital sent? <b>U.S.N. GEN. POPE DISPENSARY</b>	Location <b>U.S.N. GEN. POPE (T-AP 113)</b>			
38. Name and address of physician now attending case	<b>E. C. STINN</b>			

Signed this **19** day of **DECEMBER**, 19**66**  
at **U.S.N. GEN. POPE (T-AP 113)**

**CHIEF ENGINEER**  
(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 Roy. D. MCCANN was given first-aid treatment, or examined, on 26 NOVEMBER, 1966, at 1240 P.M., and not disabled for work. Probable length of disability will be no disability (Was or was not) not due to injury on 26 NOVEMBER, 1966 (Was or was not) In my opinion disability not

Nature of injury as found on examination FOREIGN BODY, RIGHT EYE

Hospitalized NO

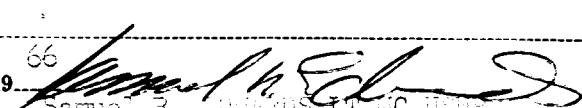
Will return for further treatment NO

Discharged .....

Other disposition FIT FOR DUTY

Remarks .....

Signed this 10 day of DECEMBER, 1966  
at USMC GEN. JOHN POPE T-AP 110

  
Samuel R. Edwards LT MC USMC

(Signature of medical officer)

LT MC USMC

(Title)