

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 <u>NAVY</u> <small>(Army, Navy, etc.)</small>	2. Bureau or office <u>U.S.T.S.</u> <small>(Engineer, Navigation, etc.)</small>
	3. Place of employment <u>USNS GEN. POPE (T-AP 113)</u> <small>(Arsenal, navy yard, etc.)</small>	(City) _____ (State) _____
	4. Reporting office <u>USNS OAKLAND, CALIFORNIA</u> <small>(Location of reporting office or division headquarters)</small>	
	5. Name of superintendent or foreman in charge when injury occurred _____	
	6. Name of injured employee <u>BOY D. MC GINNIS</u> <small>(Give first name in full)</small>	
	7. Age <u>32</u>	8. Sex <u>M</u>
	9. Citizenship <u>U.S.</u>	
	10. Home address <u>ROUTE 3, BOX 524</u> <small>(Street and number)</small>	<u>PORT ORCHARD</u> <small>(City or town)</small>
	<u>WASH.</u> <small>(State)</small>	
	11. Occupation and division <u>ENGINE UTILITY (ENG. DEPT.)</u> <small>(Give both, as laborer, hull division; helper, machine shop, etc.)</small>	12. Was employee doing his regular work? _____ If not, what work? _____
The injured employee	13. Total length of service with the Government as a civilian? <u>5 MONTHS</u>	
	14. How long at present work in this establishment? <u>5 MONTHS</u>	
	15. Dates of other injuries _____	
	16. Rate of pay on date of injury, \$ _____ per _____	{ and subsistence valued at \$ _____ per _____ { and quarters valued at \$ _____ per _____
	17. Employee begins work at <u>1200</u> a.m. <small>(Hour, a. m. or p. m.)</small>	18. Regular day's work ends <u>1700</u> p.m. <small>(Hour, a. m. or p. m.)</small>
	19. Hours worked per day <u>8 HRS.</u>	20. Days paid per week <u>7 DAYS</u>
	21. Place where injury occurred <u>USNS GEN. POPE (T-AP 113), FORWARD ENGINE ROOM</u> <small>(Give exact location, as name or number of building and division, etc.)</small>	
	22. Date of injury <u>26 NOVEMBER</u> , 19 <u>66</u> ; day of week <u>SATURDAY</u> ; hour of day <u>1130</u> a.m. <small>(a. m. or p. m.)</small>	
	23. Date employee stopped work <u>NA</u> , 19____; day of week _____; hour of day _____ m. <small>(a. m. or p. m.)</small>	
	24. Date employee's pay stopped <u>NA</u> , 19____; day of week _____; hour of day _____ m. <small>(a. m. or p. m.)</small>	
	25. Has employee returned to work? <u>YES</u> <small>(Give date and hour)</small>	
	26. Will employee receive pay for any portion of above absence on account of:	
	(a) Annual leave _____	(Give exact dates) <u>NONE</u>
	(b) Sick leave <u>NONE</u>	(Give exact dates) _____
	(c) Any other reason <u>NONE</u>	(Give exact dates) _____
	27. Describe in full how injury occurred _____ <u>WHILE STANDING NEAR THE VENTILATION, A DUST PARTICLE FROM A VENTILATOR BLEW INTO EMPLOYEE'S EYE</u>	
	28. State part of body injured and nature and extent of injury _____ <u>Right eye</u>	
The injury	29. Did injury cause loss of any member or part of member? <u>No</u> If so, describe exactly _____	
	30. Was employee injured while in performance of duty? <u>YES</u> If not, or in doubt, give detailed statement _____	
	31. Was injury caused by:	
	(a) Willful misconduct of the employee? <u>No</u>	(b) Intention of employee to bring about injury or death of himself or another? <u>No</u>
	<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? <u>YES</u> 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 _____ _____ _____ <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? <u>No</u> 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 <u>SAMUEL R. EDWARDS LT. MC USNR. (SMO)</u>	
Medical attendance	36. How soon after injury? _____	
	37. To what hospital sent? <u>USNS POPE DISPENSARY</u>	Location <u>USNS GEN. POPE (T-AP 113)</u>
	38. Name and address of physician now attending case _____ <u>D. C. GINN</u>	
Signed this _____ day of _____, 19 <u>66</u>		
at <u>OAKLAND (T-AP 113)</u>		
		<u>CHIEF ENGINEER</u> <small>(Signature of reporting officer)</small>
		<u>(Title)</u>

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. MOGIANIS was given first-aid treatment, or examined,
on 26 NOVEMBER, 1966, at 1240 Pm., and not disabled for work. Probable length of
disability will be no disability In my opinion disability not due to injury
on 26 NOVEMBER, 1966 (Was or was 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 USNS GEN. JOHN POPE T-AP 110

Samuel R. Edwards LT MC USNR

(Signature of medical officer)

LT MC USNR

(Title)