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, 114) (Arsenal, navy yard, etc.), (City), (State)
4. Reporting office FSC 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 CLARENCE C. PACK (Give first name in full) 7. Age 33 8. Sex M 9. Citizenship U.S.
10. Home address (Street and number), (City or town), (State)
11. Occupation and division WIPER (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? 1 MONTH
14. How long at present work in this establishment? 1 MONTH
15. Dates of other injuries
16. Rate of pay on date of injury, $4,786.24 per YEAR { and subsistence valued at $421.24 per YEAR; and quarters valued at $126.00 per YEAR
17. Employee begins work at 0001 (Hour, a. m. or p. m.) a. m. 18. Regular day's work ends 1701 (Hour, a. m. or p. m.) p. m.
19. Hours worked per day 8 HRS 20. Days paid per week 7

The injury

21. Place where injury occurred 3RD DECK PASSAGEWAY, #3-134-1, (Give exact location, as name or number of building and division, etc.)
22. Date of injury AUG. 29, 1966; day of week MONDAY; hour of day 0315 (a. m. or p. m.) a. m.
23. Date employee stopped work, 19; day of week; hour of day (a. m. or p. m.) m.
24. Date employee's pay stopped, 19; day of week; hour of day (a. m. or p. m.) 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 (Give exact dates)
    (b) Sick leave (Give exact dates)
    (c) Any other reason (Give exact dates)
27. Describe in full how injury occurred While passing through watertight door #3-134-1, employee stepped up on coor coming and struck his head on top of door opening.
28. State part of body injured and nature and extent of injury LACERATION OF SCALP
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? NO If not, or in doubt, give detailed statement employee is off duty on the ship.
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
    (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 SAMUEL R. EDWARDS LT. MC USNR. (SMO)
36. How soon after injury?
37. To what hospital sent? USNS POPE DISPENSARY Location USNS POPE (T-AP 114)
38. Name and address of physician now attending case

Signed this day of, 19
at

F. 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 CLARENCE C. FLOOK (Name of employee) was given first-aid treatment, or examined, on 29 AUGUST, 19 66, at 0305 m., and WAS (Was or was not) disabled for work. Probable length of disability will be 12 HOURS. In my opinion disability WAS (Was or was not) due to injury on 29 AUGUST, 19 66

Nature of injury as found on examination SCALP LACERATION

Hospitalized NO. Will return for further treatment 5th DAY (SUTURE REMOVAL)

Discharged NO. Other disposition RETURN IF NECESSARY

Remarks NO DISABILITY 12 HOURS AFTER INJURY

Signed this 12 OCTOBER ~~day of~~ OCTOBER, 19 66

at MEDICAL DEPT. USNS GEN JOHN POPE T-AP 110

Samuel R. Edwards

SAMUEL R. EDWARDS.

(Signature of medical officer)

LT MC USNR

(Title)

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