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 NAVAL SUPPLY CENTER, OAKLAND, CALIFORNIA (Activity, building, etc.) (City) (State)
4. Reporting office USNS GEN. JOHN POPE (T-AP 119) (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 EVERETT QUINN (Give first name in full) 7. Age 42 8. Sex M 9. Citizenship U.S.
10. Home address [illegible] (Street and number) (City or town) (State)
11. Occupation and division CHIEF ENGINEER (ENGINEERING 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?
14. How long at present work in this establishment?
15. Dates of other injuries
16. Rate of pay on date of injury, $ [illegible] per [illegible] and subsistence valued at $ [illegible] per [illegible]; and quarters valued at $ [illegible] per [illegible]
17. Employee begins work at [illegible] m. (Hour, a. m. or p. m.) 18. Regular day's work ends [illegible] m. (Hour, a. m. or p. m.)
19. Hours worked per day [illegible] 20. Days paid per week 7 DAYS

The injury

21. Place where injury occurred [illegible] (Give exact location, as name or number of building and division, etc.)
22. Date of injury 24 DECEMBER, 19[illegible]; day of week SATURDAY; hour of day 1630 p. m. (a. m. or p. m.)
23. Date employee stopped work [illegible], 19[illegible]; day of week [illegible]; hour of day [illegible] m. (a. m. or p. m.)
24. Date employee's pay stopped [illegible], 19[illegible]; day of week [illegible]; hour of day [illegible] m. (a. m. or p. m.)
25. Has employee returned to work? NO. (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
28. State part of body injured and nature and extent of injury BOTH EYES
29. Did injury cause loss of any member or part of member? 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 ROSS SHEPPARD,
    (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 [illegible] day of [illegible], 19[illegible]

at [illegible]

(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.]

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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