

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>M15</u> (Army, Navy, etc.)	2. Bureau or office _____	<u>ENGINEERING</u> (Engineer, Navigation, etc.)
	3. Place of employment _____ (Arsenal, navy yard, etc.)	_____ (City)	_____ (State)
	4. Reporting office _____ (Location of reporting office or division headquarters)		
	5. Name of superintendent or foreman in charge when injury occurred <u>KARP</u>		
	6. Name of injured employee <u>ROGERS</u> (Give first name in full)		7. Age <u>30</u> 8. Sex <u>M</u> 9. Citizenship <u>U.S.</u>
10. Home address _____ (Street and number)		(City or town) _____ (State) _____	
11. Occupation and division <u>ENG. UTILITY</u> (Give both, as laborer, hull division; helper, machine shop, etc.)		12. Was employee doing his regular work? <u>YES</u> If not, what work? _____	
13. Total length of service with the Government as a civilian? <u>2 MO.</u>			
14. How long at present work in this establishment? <u>2 MO.</u>			
15. Dates of other injuries _____			
16. Rate of pay on date of injury, \$ <u>5694</u> per <u>ANNUAL</u> _____ (Give exact dates)		{ and subsistence valued at \$ _____ per _____ and quarters valued at \$ _____ per _____	
17. Employee begins work at <u>0800 - 1700</u> m. 18. Regular day's work ends <u>1700</u> m. (Hour, a. m. or p. m.)		(Hour, a. m. or p. m.)	
19. Hours worked per day <u>8</u>		20. Days paid per week <u>7</u>	
21. Place where injury occurred <u>USNS HOPE TROOP GALLEY</u> (Give exact location, as name or number of building and division, etc.)			
22. Date of injury <u>6 JULY</u> , 19____; day of week <u>WED.</u> ; hour of day <u>9:30 A.M.</u> (a. m. or p. m.)			
23. Date employee stopped work _____, 19____; day of week _____; hour of day _____ m. (a. m. or p. m.)			
24. Date employee's pay stopped _____, 19____; day of week _____; hour of day _____ m. (a. m. or p. m.)			
25. Has employee returned to work? <u>YES</u> (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 <u>WELDING, USING AIR HOSE TO REMOVE DUST + SLAG THINKS PARTICLE MIGHT HAVE BEEN BLOWN IN EYES.</u>			
28. State part of body injured and nature and extent of injury <u>PARTICLE OF FOREIGN MATTER IN RIGHT EYE.</u>			
29. Did injury cause loss of any member or part of member? <u>NO</u> If so, describe exactly _____ The injury _____			
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> (c) Employee's intoxication? <u>NO</u> (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? <u>YES</u> 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 <u>CARTER, 3RD TROOP COOK</u> <u>FINLEY, PAYMASTER</u>			
(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? <u>NO</u> 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 _____			
Medical attendance	36. How soon after injury? _____		
	37. To what hospital sent? _____	Location _____	
	38. Name and address of physician now attending case _____		

Signed this _____ day of _____, 19____

(Signature of reporting officer)

at _____

(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.]

STATEMENT OF FINBEY,

Signed this day of, 19.....

(Signature of witness)

STATEMENT OF CARTER

Signed this day of, 19.....

(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that was given first-aid treatment, or examined, (Name of employee) on , 19....., at m., and disabled for work. Probable length of (Was or was not) disability will be In my opinion disability due to injury (Was or was not) 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)