

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., 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 (War, Navy, etc.)	2. Bureau or office NAVAL AIR STATION, CALIFORNIA (Arsenal, navy yard, etc.)	3. Location ON LAND (City)	4. Reporting office USAS CAMP J. M. FLETCHER, (T-AP 110) (Engin. Dept.) (Location of reporting office or division headquarters)	5. Name of superintendent or foreman in charge when injury occurred	
						ENCLOSURE
						(Engineer, Navigation, etc.)
						(State)
						(City or town)
The injured employee	6. Name of injured employee Errol A. S. JAMES (in full)	7. Age 24	8. Sex M	9. Citizenship USA		
	10. Home address	(Street and number)		(City or town)		
	11. Occupation and division	Cook (Give both, as laborer, hull division; helper, machine shop, etc.)		12. Was employee doing his regular work? No If not, what work? returning from liberty about 0645 12 JAN 1970		
	13. Total length of service with the Government as a civilian?					
	14. How long at present work in this establishment? 2 months					
	15. Dates of other injuries	Unknown				
	16. Rate of pay on date of injury, \$ 550.00 per month	and subsistence valued at \$ 421.22 per month		and quarters valued at \$ 126.00 per month		
	17. Employee begins work at 0700 (Hour, a. m. or p. m.)	18. Regular day's work ends 1600 (Hour, a. m. or p. m.)				
	19. Hours worked per day 8	20. Days paid per week 7				
	21. Place where injury occurred gangway, USAS CAMP J. M. FLETCHER, (T-AP 110) (Give exact location, as name or number of building and division, etc.)					
22. Date of injury 12 JAN , 19 70 ; day of week Monday ; hour of day 0645 m. (a. m. or p. m.)						
23. Date employee stopped work 12 JAN , 19 70 ; day of week Monday ; hour of day 0900 m. (a. m. or p. m.)						
24. Date employee's pay stopped No , 19 70 ; day of week Unknown ; hour of day 0900 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 (b) Sick leave (c) Any other reason	15 JANUARY 1970 (Give exact dates)					
27. Describe in full how injury occurred Employee was on work details when I was called to gangway area at 0645, 12 JAN 1970 and informed by him that he had slipped on the gangway upon reporting for duty at about 0645 that morning. He stated he twisted his right knee and it appeared swollen when I examined it at 0645. Employee was immediately sent to the dispensary at Hunters Point Naval Shipyard for further examination and treatment.						
28. State part of body injured and nature and extent of injury strained right knee						
29. Did injury cause loss of any member or part of member? No The injury If so, describe exactly						
30. Was employee injured while in performance of duty? No If not, or in doubt, give detailed statement returning from liberty about 0645, 12 JAN 1970.						
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 Unknown						
(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)						
35. Name and address of physician who first attended case Dispensary Hunters Point, SFNSID						
36. How soon after injury? about two (2) hours.						
37. To what hospital sent? US Public Health Service	Location 15th Ave., 4 Lake St. SF CA					
38. Name and address of physician now attending case Unknown	Office of Frank					

Signed this **12th** day of **JANUARY**, 19**70**
at **USAS CAMP J. M. FLETCHER, (T-AP 110)**

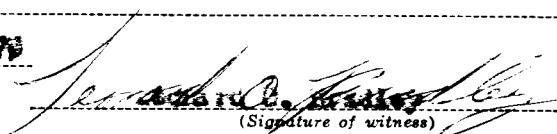
(Signature of reporting officer)
JOHN L. SANTZ
(Title)
CHIEF ENZYCO

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.]

On the 12th of Jan at 1645 when Williams and I were reporting for duty, when we were coming up the gangway Williams slipped and hurt his knee.

Signed this 12th day of Jan, 1970


(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 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)