

# 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.]

<b>Place of employment</b>	1. Department <u>NAVY</u>	2. Bureau or office <u>ENGINEERING</u>	
	(Army, Navy, etc.)		(Engineer, Navigation, etc.)
	3. Place of employment <u>Naval Supply Center</u>	<u>Oakland</u>	<u>California</u>
	(Arsenal, navy yard, etc.)		(City) (State)
	4. Reporting office <u>USNS GEN JOHN FOLEY, T AP 119</u>		
	(Location of reporting office or division headquarters)		
	5. Name of superintendent or foreman in charge when injury occurred _____		
<b>The injured employee</b>	6. Name of injured employee <u>R. J. Porter, Jr</u>	7. Age <u>46</u>	8. Sex <u>M</u>
	(Give first name in full)		
	9. Citizenship <u>USA</u>		
	10. Home address _____		
	(Street and number)		(City or town) (State)
	11. Occupation and division <u>2nd Electrician</u>	12. Was employee doing his regular work? <u>yes</u>	
	(Give both, as laborer, hull division; helper, machine shop, etc.)		
	13. Total length of service with the Government as a civilian? <u>3 years, 9 months</u>		
	14. How long at present work in this establishment? <u>3 years, 9 months</u>		
	15. Dates of other injuries <u>Unknown</u>		
	16. Rate of pay on date of injury, <u>\$ 8736.00</u> per annum	{ and subsistence valued at \$ <u>6.50</u> per day and quarters valued at \$ <u>6.50</u> per day	
	17. Employee begins work at <u>700</u> m.	18. Regular day's work ends <u>1600</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>	
<b>The injury</b>	21. Place where injury occurred <u>After Engine Room, USNS GEN WILLIAM WEIGEL (T-AP 119)</u>		
	(Give exact location, as name or number of building and division, etc.)		
	22. Date of injury <u>10 July</u> , 19 <u>69</u>	day of week <u>Thu</u> ; hour of day <u>1430</u> m.	
	(a. m. or p. m.)		
	23. Date employee stopped work <u>==</u> , 19 <u>==</u>	day of week <u>==</u> ; hour of day <u>==</u> m.	
	(a. m. or p. m.)		
	24. Date employee's pay stopped <u>==</u> , 19 <u>==</u>	day of week <u>==</u> ; hour of day <u>==</u> 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 <u>==</u>		
	(b) Sick leave <u>==</u>		
	(c) Any other reason <u>Employee reported</u>		
	(Give exact dates)		
27. Describe in full how injury occurred <u>On 10 July 1969 on or about 1430, while blowing out an electric motor with compressed air, dust blew into the employee's left eye. This accident occurred in the After Engine Room aboard the USNS WILLIAM WEIGEL, (T-AP 119). Employee washed eye with water. About 1000 11 July 1969, blood shade developed in left eye. Employee reported to Naval Dispensary at Hunters Point for treatment.</u>			
28. State part of body injured and nature and extent of injury <u>Left eye, foreign body</u>			
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> (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>None</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)			
<b>Medical attendance</b>	35. Name and address of physician who first attended case <u>N.O. ASY Hunters Point, San Fran Ca.</u>		
	36. How soon after injury? <u>within 24 hours</u>		
	37. To what hospital sent? <u>Naval Dispensary</u>	Location <u>NSY, Hunters Point, SF CA</u>	
	38. Name and address of physician now attending case <u>See attached <del>Naval Dispensary</del> NAVSO 5100/9</u>		

Signed this 11th day of July, 19 69  
 at USNS GEN JOHN FOLEY, T AP 119

OTTO L. BANTZ,  
 (Signature of reporting officer)  
Chief Engineer  
 (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.]

None

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

See attached NAVSO 5100/9

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

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)