

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>NAVY</u> (Army, Navy, etc.)	2. Bureau or office <u>NAVAL SUPPLY CENTER</u> (Arsenal, navy yard, etc.)	MSTSPAC (Engineer, Navigation, etc.)
	3. Place of employment <u>Oakland</u> (City)	4. Reporting office <u>USNS GENERAL JOHN POPE, T AP 110</u> (Location of reporting office or division headquarters)	<u>California</u> (State)
	5. Name of superintendent or foreman in charge when injury occurred _____		
	6. Name of injured employee <u>Thomas V. Bella</u> (Give first name in full)	7. Age <u>52</u>	8. Sex <u>M</u> 9. Citizenship <u>USA</u>
	10. Home address _____	(Street and number)	(City or town) _____ (State)
	11. Occupation and division <u>Oiler</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? _____	
The injured employee	13. Total length of service with the Government as a civilian? <u>20 years</u>		
	14. How long at present work in this establishment? <u>9 months</u>		
	15. Dates of other injuries <u>Unknown</u>		
	16. Rate of pay on date of injury, \$ <u>5034.00</u> per annum	and subsistence valued at \$ <u>421.20</u> per annum and quarters valued at \$ <u>126.00</u> per annum	
	17. Employee begins work at <u>0700</u> (Hour, a. m. or p. m.)	18. Regular day's work ends <u>1600</u> (Hour, a. m. or p. m.)	19. Hours worked per day <u>8</u>
21. Place where injury occurred <u>Forward Engine Room</u> (Give exact location, as name or number of building and division, etc.)			
22. Date of injury <u>22 Nov</u> , 19 <u>68</u> ; day of week <u>Friday</u> ; hour of day <u>1350</u> m. (a. m. or p. m.)	23. Date employee stopped work <u>22 Nov</u> , 19 <u>68</u> ; day of week <u>Friday</u> ; hour of day <u>1350</u> 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> , <u>11/22/68 @ 1440</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 _____ _____ _____			
28. State part of body injured and nature and extent of injury <u>Left palm, very slightly burned.</u>			
The injury	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? _____ 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 <u>NSY, Dispensary, Hunters Point, S.F. CA</u>			
Medical attendance	36. How soon after injury? <u>immediately</u>		
	37. To what hospital sent? <u>NSY Dispensary</u> Location <u>Hunters Point, S.F. CA</u>		
	38. Name and address of physician now attending case <u>Returned to work @ 1440, 11/22/68</u>		
	Signed this <u>25th</u> day of <u>NOVEMBER</u> , 19 <u>68</u> at <u>USNS GENERAL JOHN POPE, (T-AP 110)</u>		<u>M. S. CHAMBLAIN</u> (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

I CERTIFY that SEE Dispensary Permit NAVSO 5100/9 attached (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)