

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.]

	NAVY	WESPA
Place of employment	1. Department <u>ARMED FORCES</u>	2. Bureau or office <u>Engineer, Navigation, etc.</u>
	3. Place of employment <u>U.S. NAVY SUPPLY CENTER, OAKLAND</u>	<u>CALIFORNIA</u> , (State)
	4. Reporting office <u>U.S. NAVY SUPPLY CENTER, OAKLAND, (T-AP 110)</u>	(Location of reporting office or division headquarters)
	5. Name of superintendent or foreman in charge when injury occurred	
6. Name of injured employee <u>Salvatore LIVI</u> 7. Age <u>63</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>Third Electrician</u> 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>20 years</u>		
14. How long at present work in this establishment? <u>Assigned February 1968</u>		
15. Dates of other injuries <u>1951</u>		
16. Rate of pay on date of injury, \$ <u>6912.00</u> per <u>month</u> and subsistence valued at \$ <u>421.20</u> per <u>month</u> and quarters valued at \$ <u>126.00</u> per <u>month</u>		
17. Employee begins work at <u>0700</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 _____ 20. Days paid per week <u>7</u>		
21. Place where injury occurred <u>Electric Shop Storeroom</u> (Give exact location, as name or number of building and division, etc.)		
22. Date of injury <u>1 month ago</u> , 19 _____; day of week _____; hour of day _____ m.		
23. Date employee stopped work <u>9/17/68</u> , 19 _____; day of week <u>Monday</u> ; hour of day <u>1200</u> m. (a. m. or p. m.)		
24. Date employee's pay stopped <u>9/17/68</u> , 19 _____; day of week <u>Monday</u> ; hour of day <u>1200</u> m. (a. m. or p. m.)		
25. Has employee returned to work? <u>yes</u> <u>9/17/68 0700</u> (Give date and hour)		
26. Will employee receive pay for any portion of above absence on account of: (a) Annual leave <u>1200, 9/17/68 - 0700, 9/17/68</u> (exact dates) (b) Sick leave <u>—</u> (Give exact dates) (c) Any other reason <u>—</u> (Give exact dates)		
27. Describe in full how injury occurred <u>See attached statement of employee</u>		
28. State part of body injured and nature and extent of injury <u>Low back pain</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>No</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>Herbert Pak, Jr. Wiper, U.S. NAVY SUPPLY CENTER, OAKLAND, (T-AP 110)</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 <u>U.S. Dispensary, Hunters Point, S.F. Ca.</u>		
36. How soon after injury? <u>About after a month as stated by employee.</u>		
37. To what hospital sent? <u>U.S. Pub. Health Service</u> Location <u>San Francisco, California</u>		
38. Name and address of physician now attending case <u>Fit for duty 9/16/68</u>		

Signed this 17th day of September, 1968
at U.S. NAVY SUPPLY CENTER, OAKLAND, (T-AP 110)

C. A. 2
December 1961

Signature of reporting officer
Chief Engineer
(Title)

(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.]

See Form C-1

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 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

**See Medical Report of duty status
MHS 1731 Rev. 4-57 attached hereto.**

Hospitalized Will return for further treatment

Discharged Other disposition

Remarks

Signed this day of, 19.....

at

(Signature of medical officer)

(Title)