

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	NAVY	2. Bureau or office	NSPAC
	(Army, Navy, etc.)	(Arsenal, navy yard, etc.)	(City)	(Engineer, Navigation, etc.)
	3. Place of employment	NAVAL SUPPLY CENTER, Oakland	4. Reporting office	NSNS GENEVA JOHN P. POPE, (T-4P 110)
	(City)	(Location of reporting office or division headquarters)	(State)	
5. Name of superintendent or foreman in charge when injury occurred				
6. Name of injured employee David L. WENNER				
7. Age 21 8. Sex M 9. Citizenship USA				
10. Home address _____ (Street and number) _____ (City or town) _____ (State)				
The injured employee	11. Occupation and division	Third Assistant Engineer	12. Was employee doing his regular work? <input checked="" type="checkbox"/> If not, what work?	_____
	(Give both, as laborer, hull division; helper, machine shop, etc.)			
	13. Total length of service with the Government as a civilian?	2 years		
	14. How long at present work in this establishment?	1 yr		
15. Dates of other injuries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
16. Rate of pay on date of injury, \$ 99.77	per <input type="checkbox"/>	and subsistence valued at \$ 41.20	per <input type="checkbox"/>	
0000		and quarters valued at \$ 163.60	per <input type="checkbox"/>	
17. Employee begins work at <input type="checkbox"/> (Hour, a. m. or p. m.)	m.	18. Regular day's work ends <input type="checkbox"/> (Hour, a. m. or p. m.)	m.	
19. Hours worked per day	20. Days paid per week <input type="checkbox"/>			
21. Place where injury occurred After Engine Room, lower deck by #1 Food Pump.				
(Give exact location, as name or number of building and division, etc.)				
22. Date of injury 28 August	, 19 <input type="checkbox"/>	day of week <input type="checkbox"/>	hour of day <input type="checkbox"/>	m. (a. m. or p. m.)
23. Date employee stopped work <input type="checkbox"/>	, 19 <input type="checkbox"/>	day of week <input type="checkbox"/>	hour of day <input type="checkbox"/>	m. (a. m. or p. m.)
24. Date employee's pay stopped <input type="checkbox"/>	, 19 <input type="checkbox"/>	day of week <input type="checkbox"/>	hour of day <input type="checkbox"/>	m. (a. m. or p. m.)
25. Has employee returned to work? <input checked="" type="checkbox"/>	(Give date and hour) 8-26-68 overtime work			
26. Will employee receive pay for any portion of above absence on account of:				
(a) Annual leave <input type="checkbox"/>	(Give exact dates) <input type="checkbox"/>			
(b) Sick leave <input type="checkbox"/>	(Give exact dates) <input type="checkbox"/>			
(c) Any other reason <input type="checkbox"/>	(Give exact dates) <input type="checkbox"/>			
27. Describe in full how injury occurred	Mr. Wenner was assigned to remove the return steam manifold from the make-up evaporator. In the process of loosening the union type connections, he placed his feet on top of the floor plate boundary bar as a brace, as per his statement noted in item #8, Form C-1.			
28. State part of body injured and nature and extent of injury	Back and trunk			
The injury	29. Did injury cause loss of any member or part of member?	<input checked="" type="checkbox"/>	If so, describe exactly	
	Back and trunk.			
30. Was employee injured while in performance of duty? <input checked="" type="checkbox"/>	If not, or in doubt, give detailed statement			

31. Was injury caused by:	<input checked="" type="checkbox"/>			
(a) Willful misconduct of the employee? <input type="checkbox"/>	(b) Intention of employee to bring about injury or death of himself or another? <input type="checkbox"/>			
(c) Employee's intoxication? <input type="checkbox"/>				
(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? <input checked="" type="checkbox"/>	If not, did immediate superior have actual knowledge of injury? <input type="checkbox"/>			
(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	None			

(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? <input type="checkbox"/>	If so, has employee been instructed in procedure under the Bureau's regulations? <input type="checkbox"/>			
(A detailed statement should be forwarded with this report)				
Medical attendance	35. Name and address of physician who first attended case	Medical Clinic, NSC OAKLAND CALIFORNIA		
	about 48 hours.			
	36. How soon after injury? <input type="checkbox"/>			
	37. To what hospital sent? <input type="checkbox"/>	Location	NSC OAKLAND CALIFORNIA	
38. Name and address of physician now attending case	N. S. CLINIC			
USNS GENERAL JOHN P. POWELL (T-4P 110)				
Signed this day of <input type="checkbox"/> 19 <input type="checkbox"/>	60		Chief Engineer	
at				(Title)
C. A. 2 December 1961	(Signature of reporting officer)			

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.]

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
.....

Hospitalized Will return for further treatment

Discharged Other disposition

Remarks
.....

Signed this day of, 19.....

at

(Signature of medical officer)

(Title)