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 (Army, Navy, etc.) 2. Bureau or office MSTSPAC (Engineer, Navigation, etc.)
3. Place of employment USNS GEN JOHN POPE, (T-AP 110) (Arsenal, navy yard, etc.) (City) (State)
4. Reporting office (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred

The injured employee

6. Name of injured employee David I. Wenner (Give first name in full) 7. Age 28 8. Sex M 9. Citizenship USA
10. Home address (Street and number), (City or town), (State)
11. Occupation and division 3d Asst. Engineer (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? yes If not, what work?
13. Total length of service with the Government as a civilian?
14. How long at present work in this establishment?
15. Dates of other injuries Unknown
16. Rate of pay on date of injury, $ 9397 per annum { and subsistence valued at $ 421.20 per annum; and quarters valued at $ 192.60 per annum
17. Employee begins work at 0800 (Hour, a. m. or p. m.) m. 18. Regular day's work ends 1600 (Hour, a. m. or p. m.) m.
19. Hours worked per day 8 20. Days paid per week 7

The injury

21. Place where injury occurred After Engine Room, lower deck (by #4 Feed Pump) (Give exact location, as name or number of building and division, etc.)
22. Date of injury 28 August, 19 68; day of week Wednesday; hour of day 1000 (a. m. or p. m.) m.
23. Date employee stopped work ==, 19; day of week; hour of day (a. m. or p. m.) m.
24. Date employee's pay stopped ==, 19; day of week; hour of day (a. m. or p. m.) m.
25. Has employee returned to work? yes 0800, 8/29/68 (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
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 foot on top of the floor plate boundary bar as a brace, as per his statement noted in item #8, form CA-1.
28. State part of body injured and nature and extent of injury
Back and trunk.
29. Did injury cause loss of any member or part of member? No If so, describe exactly
30. Was employee injured while in performance of duty? yes If not, or in doubt, give detailed statement
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
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? No If so, has employee been instructed in procedure under the Bureau's regulations?
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case [illegible] Medical Clinic NSC Oakland CA
36. How soon after injury? about 48 hours.
37. To what hospital sent? Med. Clinic Location N.S.C. Oakland, California
38. Name and address of physician now attending case

Signed this 30th day of August, 19 68

W. S. CHAMBERLAIN (Signature of reporting officer)

at USNS GENERAL JOHN POPE, T AP 110

Chief Engineer

C. A. 2
December 1961

(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.]

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 ..... (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)

U.S. GOVERNMENT PRINTING OFFICE: 1964—O-734-915