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 NAVAL SUPPLY CENTER, OAKLAND (City), CALIFORNIA (State)
4. Reporting office USNS GENERAL JOHN POPE, (T-AP 110) (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 L. WEINER 7. Age 28 8. Sex M 9. Citizenship USA
10. Home address (Street and number), (City or town), (State)
11. Occupation and division Third Assistant 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? 2 years
14. How long at present work in this establishment? 1 yr
15. Dates of other injuries Unknown
16. Rate of pay on date of injury, $9397.00 per annum and subsistence valued at $471.20 per annum and quarters valued at $183.60 per annum
17. Employee begins work at 0800 m. (Hour, a. m. or p. m.) 18. Regular day's work ends 1600 m. (Hour, a. m. or p. 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 same, 19 same; day of week same; hour of day same (a. m. or p. m.) m.
24. Date employee's pay stopped same, 19 same; day of week same; hour of day same (a. m. or p. m.) m.
25. Has employee returned to work? yes, 8-28-68 continue work (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
    (a) Annual leave same (Give exact dates)
    (b) Sick leave same (Give exact dates)
    (c) Any other reason same (Give exact dates)
27. Describe in full how injury occurred Same as paragraph #5, Navexos 108 (Rev. 1-60)
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 Medical Clinic, NSC Oakland, California
36. How soon after injury? See attached Navexos -107 (7-52 (Dispensary Permit)
37. To what hospital sent? Medical Clinic NSC OAKLAND CALIFORNIA Location
38. Name and address of physician now attending case None

Signed this 30th day of AUGUST, 19 68 at USNS GENERAL J H POPE, T AP 110

M. S. CHAMBERLAIN
Chief Engineer
(Signature of reporting officer) (Title)

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.]

NONE.

Signed this ..... day of ....., 19.....

(Signature of witness)

NONE.

Signed this ..... day of ....., 19.....

(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that See attached Navexos -107 (7-52) Dispensary Permit 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)

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