

U.S. DEPARTMENT OF LABOR  
Bureau of Employees' Compensation

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE  
(Under the Federal Employees' Compensation Act)

INSTRUCTIONS

This form should be completed by the injured employee or someone on his behalf whenever an injury is sustained in the performance of duty and given to his immediate superior within 48 hours. It should be placed in the employee's official personnel file unless the injury causes disability for work beyond the day when it occurred; is likely to result in prolonged treatment or permanent disability; or in a charge for medical or related expenses when it should be forwarded to this Bureau with Form CA-2, Official Superior's Report of Injury. This form is also completed whenever an employee believes he suffers from a disease related to his employment. (See Sections 1.2, 1.3, 2.2 and 2.3 of the Bureau's Regulations.)

The immediate superior should also complete the reverse side of this form.

1. NAME OF INJURED EMPLOYEE (Last, first, middle)

THEODORE FRICK

3. PLACE OF EMPLOYMENT (Name and location of office or establishment)

CARP-GATE GEN. JOHN PODE

5. OCCUPATION

CARP-GATE

7. PLACE OR LOCATION WHERE INJURY OCCURRED

FORN'D - on BOY -

8. CAUSE OF INJURY (Describe how and why injury occurred)

BOY SLIPPED OFF WINDOW - WHILE  
DANCING

9. NATURE OF INJURY (Name part of body affected—fractured left leg, bruised right thumb, etc.)

SCAPULA

10. NAMES OF WITNESSES TO INJURY

11. IF THIS NOTICE WAS NOT GIVEN WITHIN 48 HOURS AFTER THE INJURY, EXPLAIN REASON FOR DELAY. IF EARLIER NOTICE WAS GIVEN, VERBAL OR WRITTEN, STATE WHEN AND TO WHOM.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.

12. SIGNATURE

Theodore Frick

13. HOME ADDRESS OF INJURED EMPLOYEE

1111 NEXX P. C.  
5TH UNIT  
SAN FRANCISCO, CALIF.

## STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit statement and secure statements of witnesses if possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. DATE CA-1 RECEIVED BY AGENCY (Mo., day, yr.)

15. CA-1 RECEIVED BY WHOM

16. STATEMENT OF IMMEDIATE SUPERIOR

While attempting to bring anchor  
windlass out of gear turning bar  
slipped from slot striking man on  
head with downward pressure applied.  
immediately sent to hospital.

17. SIGNATURE OF IMMEDIATE SUPERIOR

18. DATE (Mo., day, yr.)

19. STATEMENT OF WITNESS

Injury happened as stated

20. SIGNATURE OF WITNESS

Alvy O. Buenturado

21. DATE (Mo., day, yr.)

22. STATEMENT OF WITNESS

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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23. SIGNATURE OF WITNESS

24. DATE (Mo., day, yr.)