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)*: HERNANDEZ JR. LEONARDO

2. DATE OF THIS NOTICE *(Mo., day, yr.)*: 1/22/66

3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*: USNS JOHN POPE T-AP 110

4. DATE OF INJURY *(Mo., day, yr.)*: 1/22/66

5. OCCUPATION: ORDINARY SEAMAN

6. HOUR OF INJURY *(a.m. or p.m.)*: 1140 (a.m.)

7. PLACE OR LOCATION WHERE INJURY OCCURRED: AFTER DOCKING STATION USNS POPE T-AP 110

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

DOCKING SHIP IN HONOLULU PIER 40, I WAS HOLDING THE INSHORE LINE WITH THE STOPPER WHILE IT WAS BEING SLAKED (SLACKED) OFF THE CAPSTAN (TAIN) TO BE SECURED ON THE BITTS, THE STOPPER BROKE WITH THE STRAIN ON THE LINE. WRAPPED AROUND MY RIGHT LEG AND BRUISED IT.

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

BRUISED RIGHT LEG " 8 Inches BELOW RIGHT KNEE, PEELED SKIN THEN AREA TURNED BLUE.

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:

13. HOME ADDRESS OF INJURED EMPLOYEE:

STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit a statement and secure statements of witnesses where 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

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*

19. STATEMENT OF WITNESS

I WAS PRESENT WHEN THE STOPPER BROKE WITH THE STRAIN OF THE LINE AND WRAPPED AROUND HERNANDEZ LEG.

20. SIGNATURE OF WITNESS	21. DATE *(Mo., day, yr.)*
Harold M Sackett	1/22/66

22. STATEMENT OF WITNESS

I WAS ON THE SAME DOCKING STATION WHEN THE STOPPER BROKE AND CAUGHT HERNANDEZ LEG AND BRUISED IT.

23. SIGNATURE OF WITNESS	24. DATE *(Mo., day, yr.)*
Conrad W. Gerke	1/22/66

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