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)*
LEWIS, EUGENE EARL

2. DATE OF THIS NOTICE *(Mo., day, yr.)*
2-17-66

3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*
USNS GEN JOHN POPE TAP-11Ø

4. DATE OF INJURY *(Mo., day, yr.)*
8 FEBRUARY 1966

5. OCCUPATION
1ST ASST RADIO OFFICER

6. HOUR OF INJURY *(a.m. or p.m.)*
2 PM (APPROX)

7. PLACE OR LOCATION WHERE INJURY OCCURRED
1ST ASST RADIO OFFICER'S STATEROOM

8. CAUSE OF INJURY *(Describe how and why injury occurred)*
INJURED BACK WHILE DOING SITUP EXERCISE'S

9. NATURE OF INJURY *(Name part of body affected—fractured left leg, bruised right thumb, etc.)*
DIAGNOSIS BY DOCTOR: STRAIN, LUMBAR MUSCLE

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.
SERIOUSNESS OF CONDITION NOT APPARENT UNTIL 2-17-66

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
Eugene E Lewis

13. HOME ADDRESS OF INJURED EMPLOYEE
1329 TEELIN WAY, VISTA CALIFORNIA

Form CA-1, Apr. 1962. Edition of Oct. 1952 may be used.

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

Man ADVISED in A few days he had hurt back in a course of Conversation - And Advised on 2-17-66 Unable to perform Duties.

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*
C. J. Summa	2-17-66

19. STATEMENT OF WITNESS

20. SIGNATURE OF WITNESS	21. DATE *(Mo., day, yr.)*

22. STATEMENT OF WITNESS

23. SIGNATURE OF WITNESS	24. DATE *(Mo., day, yr.)*

* U.S. GOVERNMENT PRINTING OFFICE : 1964 OF—723-862

MORNING REPORT OF SICK
NAVMED-T (Rev. 2-45)

USNS GENERAL JOHN POPE (T-AP 110)
c/o FLEET POST OFFICE
SAN FRANCISCO, CALIFORNIA 96601

TO: COMMANDING OFFICER

DATE 17 February, 19 66

NAME	GRADE	DIAGNOSIS	REMARKS
ADMISSIONS:			
LEWIS, Eugene Earl, First Assistant Radio Officer, Z678502, Deck Dept.		Strain, Lumbar Muscle	
TRANSFERRED:			
None			
DISCHARGED:			
None			
REMAINING:			
LEWIS, Eugene Earl			
BINNICLE LIST:			
None			
Copy to: CO, Military Chaplain National Records Office			

ADMITTED 1
DISCHARGED 0
REMAINING 1
BINNICLE LIST 0

SIGNATURE J. L. KITZMILLER, LT, (MC), U. S. N.
(MEDICAL OFFICER)

NAVEXOS-108 (REV. 1-60)
EXCEPTION TO STANDARD FORM 92
APPROVED BY BUREAU OF THE BUDGET, JAN. 1960

ACCIDENT REPORT

REPORT EXOS-5100-6

DATE (Day, Month, Year): 17 February,1966

1. REPORTING SHIP, ACTIVITY OR UNIT	FLEET OR NAV. DIST. NO.	Do not use
USNS GENERAL JOHN POPE (T AP 11ø)	12 ND	

2. PERSONNEL INJURED (Name, Rank, Rate or Trade, and Branch of Service)	AGE	YEARS EXPER.	DUTY OR WORK ASSIGNMENT: REG.	TEMP.	RECR.	LV/LIB.	TRAV.	OTHER	EST. DAYS LOST OR TIME CHGS.	TOTAL DISABLING INJURIES
Eugene Earl Lewis,1st Ass't Radio Opr	4ø	2ø	X						2ø hrs	

3. PROPERTY/EQUIPMENT DAMAGE: TYPE	OWNERSHIP	LABOR	ESTIMATED DAMAGE COST: MATERIAL	OVERHEAD	TOTAL

4. DATE AND TIME OF ACCIDENT: HOUR	DAY	MONTH	YEAR	WEATHER: GOOD	ADVERSE	NOT APPLIC.	LIGHT: GOOD	POOR	NOT APPLIC.
2-PM	8	February	1966	X			X		

5. DESCRIPTION OF ACCIDENT: *Describe the accident so that the Reviewing Official can get a clear picture of the accident and the reasons for it. Select and check closest applicable item in each section on back of form.*

Apparent Back Strain Occured as Result of Exercise, as advised by Mr. Lewis.

6. FORMS SUBMITTED APPLICABLE TO INJURED CIVILIAN EMPLOYEES
A. C.A.1 [X] YES [ ] NO B. C.A.2 [X] YES [ ] NO C. OTHER (INDICATE):

7. RECOMMENDED CORRECTIVE ACTION: *What recommendations have been made which will help prevent another accident like this?*
Admonished Individual to use Due Caution and moderation in Exercise

SIGNATURE OF SUPERVISOR, CHIEF OF WORKING PARTY OR HEAD OF WORK DETAIL: C.F. SUMNER	TITLE, RANK, RATE OR GRADE: Chief Radio Officer	DATE: 2-17-'66

8. REVIEW AND COMMENT OF REVIEWING OFFICIAL

SIGNATURE OF REVIEWING OFFICIAL: H.L. HEINZ	TITLE, RANK, RATE OR GRADE: MASTER	DATE: 2-17-'66

SECTION 9 AGENCY INVOLVED

Check (x) and specify in space provided the object or substance most closely associated with the injury and which in general could have been properly guarded or corrected. One check (x) MUST be entered in this section.

Do not use

- [ ] 1. MACHINES: *(Agitators, grinders, sewing machines, vices, saws, lathes, welding machines, etc.)*
- [ ] 2. PRIME MOVERS & PUMPS: *(Steam, internal combustion or air; compressors, fans, blowers, etc.)*
- [ ] 3. ELEVATORS: *(Passenger, freight, aircraft or dumbwaiters)*
- [ ] 4. HOISTING APPARATUS: *(Cranes, hoists (air or electric), shovels, dredges, jacks, etc.)*
- [ ] 5. CONVEYORS: *(Belt, monorail, pneumatic, drag line, tiering or piling, etc.)*
- [ ] 6. BOILERS & PRESSURE VESSELS: *(Fired or unfired, pressure lines, etc.)*
- [ ] 7. VEHICLES: *(All types, except in traffic or flight)*
- [ ] 8. ANIMALS: *(Including insects and reptiles)*
- [ ] 9. MECHANICAL POWER TRANSMISSION APPARATUS: *(Belts, gears, couplings, etc.)*
- [ ] 10. ELECTRICAL APPARATUS: *(Motors, transformers, lamps, appliances, etc.)*
- [ ] 11. HAND TOOLS: *(Hand, mechanical or electrical motive power; hammers, wrenches, welding tools, sandblasters, etc.)*
- [ ] 12. CHEMICALS: *(Explosives, gases, vapors, acids, caustics, poisonous vegetations, etc.)*
- [ ] 13. HIGHLY INFLAMMABLE & HOT SUBSTANCES: *(Fire, alcohol, steam, paints, etc.)*
- [ ] 14. DUSTS: *(Explosive, organic or inorganic; leather, emery, coal, etc.)*
- [ ] 15. RADIATIONS & RADIATING SUBSTANCES: *(X-Ray, radium, ultra violet rays, etc.)*
- [XX] 16. WORKING SURFACES: *(Floors, decks, roofs, roads, stairs, platforms, stagings, scaffolds, etc.)*
- [ ] 17. AGENCIES: *(Any object or substance not otherwise classified.)*

WHAT PART OF AGENCY CHECKED (X) ABOVE WAS MOST CLOSELY INVOLVED?

SECTION 10 UNSAFE MECHANICAL CONDITION

Check (x) and specify the PRINCIPAL unsafe condition which led to or was responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 18. IMPROPER GUARDING: *(Unguarded, inadequately guarded, etc.)*
- [ ] 19. DEFECTIVE SUBSTANCES OR EQUIPMENT: *(Broken, rough, slippery, poorly designed, etc.)*
- [ ] 20. HAZARDOUS ARRANGEMENT: *(Unsafe piling, poor layout, etc.)*
- [ ] 21. IMPROPER ILLUMINATION: *(Insufficient light, glare, etc.)*
- [ ] 22. IMPROPER VENTILATION: *(Dusty, gassy, impure air source, etc.)*
- [ ] 23. UNSAFE CLOTHING: *(Lack of, unmated or defective shoes, goggles, gloves, respirators, etc.)*
- [X] 24. NO UNSAFE CONDITION:
- [ ] 25. UNSAFE CONDITION NOT OTHERWISE CLASSIFIED : *(Explain)*

SECTION 11 TYPE OF ACCIDENT

Check (x) type of accident. One check (x) MUST be entered in this section.

- [ ] 26. STRIKING AGAINST *(Contact with rough or sharp objects, resulting in cuts etc., due to striking against, kneeling on, or slipping on objects.*
- [ ] 27. STRUCK BY *(Falling, flying, sliding, or moving objects.)*
- [ ] 28. CAUGHT IN, ON, OR BETWEEN.
- [ ] 29. FALL ON SAME LEVEL.
- [ ] 30. FALL TO DIFFERENT LEVEL.
- [X] 31. SLIP *(not fall)* OR OVER-EXERTION. *(Resulting in strain, hernia, etc.)*
- [ ] 32. EXPOSURE TO TEMPERATURE EXTREMES. *(Resulting in burning, scalding, heat exhaustion, sunstroke, freezing, etc.)*
- [ ] 33. INHALATION, ABSORPTION, SWALLOWING. *(Asphyxiation, poisoning, drowning, etc.)*
- [ ] 34. CONTACT WITH ELECTRIC CURRENT.
- [ ] 35. ELECTRIC WELDING FLASH.
- [ ] 36. FOREIGN BODIES IN EYE. *(Resulting from dust, chips, airborne particles, etc.)*
- [ ] 37. TYPE OF ACCIDENT NOT OTHERWISE CLASSIFIED. *(Explain)*

SECTION 12 UNSAFE ACT

Check (x) and explain PRINCIPAL unsafe act. One check (x) MUST be entered in this section.

- [ ] 38. OPERATING WITHOUT AUTHORITY. *(Failure to secure or warn)*
- [ ] 39. OPERATING OR WORKING AT UNSAFE SPEED. *(Too slow, too fast, throwing materials, etc.)*
- [ ] 40. MAKING SAFETY DEVICES INOPERATIVE. *(Removing, misadjusting, disconnecting, etc.)*
- [ ] 41. USING UNSAFE EQUIPMENT, HANDS INSTEAD OF EQUIPMENT, OR EQUIPMENT UNSAFELY.
- [ ] 42. UNSAFE LOADING, PLACING, MIXING, ETC.
- [X] 43. UNSAFE POSITION, POSTURE OR ACT, ETC. *(Under suspended loads, lifting with bent back, etc.)*
- [ ] 44. WORKING ON MOVING OR DANGEROUS EQUIPMENT. *(Cleaning, adjusting, oiling, etc.)*
- [ ] 45. DISTRACTING, TEASING, ABUSING, STARTLING, ETC. *(Quarreling, horseplay, etc.)*
- [ ] 46. FAILURE TO USE SAFE CLOTHING OR PERSONAL PROTECTIVE DEVICES. *(Hats, goggles, etc.)*
- [ ] 47. NO UNSAFE ACT.
- [ ] 48. UNSAFE ACT NOT OTHERWISE CLASSIFIED *(Explain)*

SECTION 13 UNSAFE PERSONAL FACTOR

Check (x) and explain the unsafe personal factor chiefly responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 49. IMPROPER ATTITUDE *(Disregard of instructions, failure to understand instructions, nervous, excitable, etc.)*
- [ ] 50. LACK OF KNOWLEDGE OR SKILL *(Unaware of safe practice, unskilled, etc.)*
- [ ] 51. BODILY DEFECTS *(Defective eyesight, hearing; fatigue, intoxicated, existing hernia, weak heart, etc.)*
- [X] 52. NO UNSAFE PERSONAL FACTOR:
- [ ] 53. UNSAFE PERSONAL FACTOR NOT ELSEWHERE CLASSIFIED *(Explain)*:

SECTION 14 TYPE OF INJURY

Check (x) type of injury, one check (x) MUST be entered in this section.

- [ ] 54. WOUNDS *(Concussion, abrasion, incision, laceration)*
- [ ] 55. SPRAINS
- [X] 56. STRAINS *(Muscular)*
- [ ] 57. HERNIA
- [ ] 58. FRACTURES
- [ ] 59. AMPUTATIONS *(Loss of bony substances)*
- [ ] 60. AVULSION *(Loss of non-bony substance by shearing or tearing away)*
- [ ] 61. BURNS AND SCALDS
- [ ] 62. FOREIGN BODY IMBEDDED
- [ ] 63. FOREIGN BODY, LOOSE *(Dust, etc.)*
- [ ] 64. FLASHES
- [ ] 65. FUMES AND GASES
- [ ] 66. POISONS
- [ ] 67. SKIN DISEASE *(Occupational)*
- [ ] 68. TYPE OF INJURY NOT OTHERWISE CLASSIFIED: *(Drowning, Electrocution, Heat Exhaustion, etc.)*

SECTION 15 PART OF BODY

Check (x) part of body. Part of body chiefly identified with injury MUST be checked (x).

- [ ] 69. HEAD FACE
- [ ] 70. BACK
- [ ] 71. EYES
- [ ] 72. TRUNK
- [ ] 73. ARMS
- [ ] 74. HANDS
- [ ] 75. FINGERS
- [ ] 76. LEGS
- [ ] 77. FEET
- [ ] 78. TOES
- [ ] 79. SYSTEMIC *(Stomach, intestines, lungs, heart, nerves, etc.)*
- [ ] 80. PART OF BODY NOT ELSEWHERE CLASSIFIED: *(Explain)*

NAVEXOS-108 (REV. 1-60)
EXCEPTION TO STANDARD FORM 92
APPROVED BY BUREAU OF THE BUDGET, JAN. 1960

ACCIDENT REPORT

REPORT EXOS-5100-6

DATE (Day, Month, Year): _____

1. REPORTING SHIP, ACTIVITY OR UNIT: USNS GEN JOHN POPE TAP 110 | FLEET OR NAV. DIST. NO. | Do not use

2. PERSONNEL INJURED (Name, Rank, Rate or Trade, and Branch of Service)	AGE	YEARS EXPER.	DUTY OR WORK ASSIGNMENT: REG.	TEMP.	RECR.	LV/LIB.	TRAV.	OTHER	EST. DAYS LOST OR TIME CHGS	TOTAL DISABLING INJURIES
EUGENE EARL LEWIS, 1ST ASST RAD. OFFR	39								20 hrs	

3. PROPERTY/EQUIPMENT DAMAGE

TYPE	OWNERSHIP	ESTIMATED DAMAGE COST: LABOR	MATERIAL	OVERHEAD	TOTAL

4. DATE AND TIME OF ACCIDENT: HOUR	DAY	MONTH	YEAR	WEATHER: GOOD	ADVERSE	NOT APPLIC.	LIGHT: GOOD	POOR	NOT APPLIC.
2 Pm	8	FEB	66	X			X		

5. DESCRIPTION OF ACCIDENT: *Describe the accident so that the Reviewing Official can get a clear picture of the accident and the reasons for it. Select and check closest applicable item in each section on back of form.*

X APPARENT BACK STRAIN — OCCURRED AS RESULT OF EXERCISING AS ADVISED BY MR. LEWIS.

6. FORMS SUBMITTED APPLICABLE TO INJURED CIVILIAN EMPLOYEES
A. C.A.1 ☐ YES ☐ NO B. C.A.2 ☐ YES ☐ NO C. OTHER (INDICATE): _____

7. RECOMMENDED CORRECTIVE ACTION: *What recommendations have been made which will help prevent another accident like this?*

X ADMONISHED INDIVIDUAL TO USE DUE CAUTION AND MODERATION IN EXERCISE

SIGNATURE OF SUPERVISOR, CHIEF OF WORKING PARTY OR HEAD OF WORK DETAIL	TITLE, RANK, RATE OR GRADE	DATE
C. J. Summer	Chief Radio Opr	

8. REVIEW AND COMMENT OF REVIEWING OFFICIAL

SIGNATURE OF REVIEWING OFFICIAL:	TITLE, RANK, RATE OR GRADE	DATE

SECTION 9 AGENCY INVOLVED

Check (x) and specify in space provided the object or substance most closely associated with the injury and which in general could have been properly guarded or corrected. One check (x) MUST be entered in this section. *Do not use*

- [ ] 1. MACHINES: _____ *(Agitators, grinders, sewing machines, vices, saws, lathes, welding machines, etc.)*
- [ ] 2. PRIME MOVERS & PUMPS: _____ *(Steam, internal combustion or air; compressors, fans, blowers, etc.)*
- [ ] 3. ELEVATORS: _____ *(Passenger, freight, aircraft or dumbwaiters)*
- [ ] 4. HOISTING APPARATUS: _____ *(Cranes, hoists (air or electric), shovels, dredges, jacks, etc.)*
- [ ] 5. CONVEYORS: _____ *(Belt, monorail, pneumatic, drag line, tiering or piling, etc.)*
- [ ] 6. BOILERS & PRESSURE VESSELS: _____ *(Fired or unfired, pressure lines, etc.)*
- [ ] 7. VEHICLES: _____ *(All types; except in traffic or flight)*
- [ ] 8. ANIMALS: _____ *(Including insects and reptiles)*
- [ ] 9. MECHANICAL POWER TRANSMISSION APPARATUS: _____ *(Belts, gears, couplings, etc.)*
- [ ] 10. ELECTRICAL APPARATUS: _____ *(Motors, transformers, lamps, appliances, etc.)*
- [ ] 11. HAND TOOLS: _____ *(Hand, mechanical or electrical motive power; hammers, wrenches, welding tools, sandblasters, etc.)*
- [ ] 12. CHEMICALS: _____ *(Explosives, gases, vapors, acids, caustics, poisonous vegetations, etc.)*
- [ ] 13. HIGHLY INFLAMMABLE & HOT SUBSTANCES: _____ *(Fire, alcohol, steam, paints, etc.)*
- [ ] 14. DUSTS: _____ *(Explosive, organic or inorganic; leather, emery, coal, etc.)*
- [ ] 15. RADIATIONS & RADIATING SUBSTANCES: _____ *(X-Ray, radium, ultra violet rays, etc.)*
- [x] 16. WORKING SURFACES: DECK *(Floors, decks, roofs, roads, stairs, platforms, stagings, scaffolds, etc.)*
- [ ] 17. AGENCIES: _____ *(Any object or substance not otherwise classified.)*

WHAT PART OF AGENCY CHECKED (X) ABOVE WAS MOST CLOSELY INVOLVED?

SECTION 10 UNSAFE MECHANICAL CONDITION

Check (x) and specify the PRINCIPAL unsafe condition which led to or was responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 18. IMPROPER GUARDING: _____ *(Unguarded, inadequately guarded, etc.)*
- [ ] 19. DEFECTIVE SUBSTANCES OR EQUIPMENT: _____ *(Broken, rough, slippery, poorly designed, etc.)*
- [ ] 20. HAZARDOUS ARRANGEMENT: _____ *(Unsafe piling, poor layout, etc.)*
- [ ] 21. IMPROPER ILLUMINATION: _____ *(Insufficient light, glare, etc.)*
- [ ] 22. IMPROPER VENTILATION: _____ *(Dusty, gassy, impure air source, etc.)*
- [ ] 23. UNSAFE CLOTHING: _____ *(Lack of, unsuited or defective shoes, goggles, gloves, respirators, etc.)*
- [x] 24. NO UNSAFE CONDITION:
- [ ] 25. UNSAFE CONDITION NOT OTHERWISE CLASSIFIED : *(Explain)* _____

SECTION 11 TYPE OF ACCIDENT

Check (x) type of accident. One check (x) MUST be entered in this section.

- [ ] 26. STRIKING AGAINST *(Contact with rough or sharp objects resulting in cuts, etc., due to striking against, kneeling on, or slipping on objects.*
- [ ] 27. STRUCK BY *(Falling, flying, sliding, or moving objects.)*
- [ ] 28. CAUGHT IN, ON, OR BETWEEN.
- [ ] 29. FALL ON SAME LEVEL.
- [ ] 30. FALL TO DIFFERENT LEVEL.
- [x] 31. SLIP *(not fall)* OR OVER-EXERTION. *(Resulting in strain, hernia, etc.)*
- [ ] 32. EXPOSURE TO TEMPERATURE EXTREMES. *(Resulting in burning, scalding, heat exhaustion, sunstroke, freezing, etc.)*
- [ ] 33. INHALATION, ABSORPTION, SWALLOWING. *(Asphyxiation, poisoning, drowning, etc.)*
- [ ] 34. CONTACT WITH ELECTRIC CURRENT.
- [ ] 35. ELECTRIC WELDING FLASH.
- [ ] 36. FOREIGN BODIES IN EYE. *(Resulting from dust, chips, airborne particles, etc.)*
- [x] 37. TYPE OF ACCIDENT NOT OTHERWISE CLASSIFIED. *(Explain)* normal exercise

SECTION 12 UNSAFE ACT

Check (x) and explain PRINCIPAL unsafe act. One check (x) MUST be entered in this section.

- [ ] 38. OPERATING WITHOUT AUTHORITY. *(Failure to secure or warn)*
- [ ] 39. OPERATING OR WORKING AT UNSAFE SPEED. *(Too slow, too fast, throwing materials, etc.)*
- [ ] 40. MAKING SAFETY DEVICES INOPERATIVE. *(Removing, misadjusting, disconnecting, etc.)*
- [ ] 41. USING UNSAFE EQUIPMENT, HANDS INSTEAD OF EQUIPMENT, OR EQUIPMENT UNSAFELY.
- [ ] 42. UNSAFE LOADING, PLACING, MIXING, ETC.
- [x] 43. UNSAFE POSITION, POSTURE OR ACT, ETC. *(Under suspended loads, lifting with bent back, etc.)*
- [ ] 44. WORKING ON MOVING OR DANGEROUS EQUIPMENT *(Cleaning, adjusting, oiling, etc.)*
- [ ] 45. DISTRACTING, TEASING, ABUSING, STARTLING, ETC. *(Quarreling, horseplay, etc.)*
- [ ] 46. FAILURE TO USE SAFE CLOTHING OR PERSONAL PROTECTIVE DEVICES. *(Hats, goggles, etc.)*
- [x] 47. NO UNSAFE ACT.
- [ ] 48. UNSAFE ACT NOT OTHERWISE CLASSIFIED *(Explain)*

SECTION 13 UNSAFE PERSONAL FACTOR

Check (x) and explain the unsafe personal factor chiefly responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 49. IMPROPER ATTITUDE *(Disregard of instructions, failure to understand instructions, nervous, excitable, etc.)*
- [ ] 50. LACK OF KNOWLEDGE OR SKILL *(Unaware of safe practice, unskilled, etc.)*
- [ ] 51. BODILY DEFECTS *(Defective eyesight, hearing, fatigue, intoxicated, existing hernia, weak heart, etc.)*
- [x] 52. NO UNSAFE PERSONAL FACTOR:
- [x] 53. UNSAFE PERSONAL FACTOR NOT ELSEWHERE CLASSIFIED *(Explain)*: history of low back strain

SECTION 14 TYPE OF INJURY

Check (x) type of injury, one check (x) MUST be entered in this section.

- [ ] 54. WOUNDS *(Concussion, abrasion, incision, laceration)*
- [ ] 55. SPRAINS
- [x] 56. STRAINS *(Muscular)*
- [ ] 57. HERNIA
- [ ] 58. FRACTURES
- [ ] 59. AMPUTATIONS *(Loss of bony substances)*
- [ ] 60. AVULSION *(Loss of non-bony substance by shearing or tearing away)*
- [ ] 61. BURNS AND SCALDS
- [ ] 62. FOREIGN BODY IMBEDDED
- [ ] 63. FOREIGN BODY, LOOSE *(Dust, etc.)*
- [ ] 64. FLASHES
- [ ] 65. FUMES AND GASES
- [ ] 66. POISONS
- [ ] 67. SKIN DISEASE *(Occupational)*
- [ ] 68. TYPE OF INJURY NOT OTHERWISE CLASSIFIED: *(Drowning, Electrocution, Heat Exhaustion, etc.)*

SECTION 15 PART OF BODY

Check (x) part of body. Part of body chiefly identified with injury MUST be checked (x).

- [ ] 69. HEAD FACE
- [x] 70. BACK
- [ ] 71. EYES
- [ ] 72. TRUNK
- [ ] 73. ARMS
- [ ] 74. HANDS
- [ ] 75. FINGERS
- [ ] 76. LEGS
- [ ] 77. FEET
- [ ] 78. TOES
- [ ] 79. SYSTEMIC *(Stomach, intestines, lungs, heart, nerves, etc.)*
- [ ] 80. PART OF BODY NOT ELSEWHERE CLASSIFIED: *(Explain)*

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 ~~Dept of Navy~~ (Army, Navy, etc.) 2. Bureau or office Radio - MSTS (Engineer, Navigation, etc.)
3. Place of employment USNS GEN JOHN POPE - TAPIO c/o FPO SAN FRAN (Arsenal, navy yard, etc.) (City) (State)
4. Reporting office COMSTSPAC / FORT MASON, SAN FRANCISCO, CALIF. (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred C. F. SUMNER

The injured employee

6. Name of injured employee EUGENE EARL LEWIS (Give first name in full) 7. Age 39 8. Sex M 9. Citizenship U.S.
10. Home address 1329 TREAU WAY (Street and number), VISTA (City or town), CALIF. (State)
11. Occupation and division RADIO OFFICER (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? NO If not, what work? OFF DUTY - EXERCISING
13. Total length of service with the Government as a civilian? 8 MOS -
14. How long at present work in this establishment? 85 DAYS
15. Dates of other injuries —
16. Rate of pay on date of injury, $ 9410.00 per ANNUM { and subsistence valued at $ — per ; and quarters valued at $ — per
17. Employee begins ~~work~~ WATCH at VARIOUS m. (Hour, a. m. or p. m.) 18. Regular day's work ends VARIOUS m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 OR MORE 20. Days paid per week 7

The injury

21. Place where injury occurred 1ST RADIOOFFICER'S STATE Room, USNS POPE. (Give exact location, as name or number of building and division, etc.)
22. Date of injury 2-8-66, 19—; day of week TUESDAY; hour of day 2 P. m. (a. m. or p. m.)
23. Date employee stopped work 2-17, 1966; day of week THURSDAY; hour of day 3 P. m. (a. m. or p. m.)
24. Date employee's pay stopped —, 19—; day of week —; hour of day — m. (a. m. or p. m.)
25. Has employee returned to work? YES - 2-19-66 - (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave NO (Give exact dates)
(b) Sick leave 2-17-66, 2-18-66 (EACH 8 HRS) 2-19-66 - (4 HRS) (Give exact dates)
(c) Any other reason — (Give exact dates)
27. Describe in full how injury occurred ROUTINE EXERCISE - SIT UPS -
28. State part of body injured and nature and extent of injury AS PER Doctor's REPORT - LUMBAR MUSCLE -
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? NO If not, or in doubt, give detailed statement EXERCISING - OFF DUTY HOURS
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? NO If not, did immediate superior have actual knowledge of injury? YES
(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 J. L. KITZ MILLER, LT. MC, USN
36. How soon after injury? 9 DAYS
37. To what hospital sent? SHIPS Location USNS GEN JOHN POPE
38. Name and address of physician now attending case J. L. KITZ MILLER, LT. MC, USN

Signed this — day of —, 19— C. F. Sumner (Signature of reporting officer)
at — Comd Radio Off (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.]

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)

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