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 MSTS (Engineer, Navigation, etc.)
3. Place of employment USNS GEN. POPE (Arsenal, navy yard, etc.), (City), (State)
4. Reporting office CAMC (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred W. PURCHASE

The injured employee

6. Name of injured employee MARTIN COLLINS (Give first name in full) 7. Age ____ 8. Sex M 9. Citizenship U.S.
10. Home address ____ (Street and number), ____ (City or town), ____ (State)
11. Occupation and division BOATSWAIN' DECK DEPARTMENT (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? 2 mo.
15. Dates of other injuries ____
16. Rate of pay on date of injury, $10,400 per ANNUM and subsistence valued at $ 6.30 per DAY and quarters valued at $ 6.50 per DAY
17. Employee begins work at 7 A m. (Hour, a. m. or p. m.) 18. Regular day's work ends 16:00 P m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 20. Days paid per week 7

21. Place where injury occurred PIER #2 BERTH #32 NSY HUNTER'S POINT (Give exact location, as name or number of building and division, etc.)
22. Date of injury ~~MAY~~ SEPT. 4, 1968; day of week WED; hour of day 0730 (a. m. or p. m.)
23. Date employee stopped work —, 19—; day of week —; hour of day — (a. m. or p. m.)
24. Date employee's pay stopped —, 19—; day of week —; hour of day — (a. m. or p. m.)
25. Has employee returned to work? YES - NO LOST TIME. (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 EMPLOYEE WAS SUPERVISING ASSEMBLY OF RAMP IN PREPERATION OF LOADING STORES. HE BACKED INTO A STEAM AND WATER ~~UNCOUPLED~~ CONNECTION OPENING IN THE DECK OF THE PIER. OPENING HAS NO SAFETY CHAIN ON SIDE FACING SHIP.
28. State part of body injured and nature and extent of injury ABRASION - INSIDE RT. FARM & SMALL SCRATCH UPPER LFT. THIGH.

The injury

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? ~~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 ____
(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 N.C. - WHANAKE KIRIC MC/2
36. How soon after injury? 5 MIN
37. To what hospital sent? NONE Location —
38. Name and address of physician now attending case NONE

Signed this ____ day of ____, 19____ ____ (Signature of reporting officer)
at ____ ____ (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.]

THE BOATSWAIN WAS HELPING TO SET UP THE LOADING RAMP AT THE AFT SIDE PORT. HE WAS STANDING ON THE PIER AND WHEN HE BACKED UP HE FELL THROUGH A HOLE IN THE DECK OF THE PIER. THERE WAS NO SAFETY CHAIN ON THE SIDE OF THE HOLE WHERE HE FELL.

Signed this ..... day of ....., 19..... Joseph P Paine 573-7

(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 MARTIN COLLINS (Name of employee) was given first-aid treatment, or examined, on 4 SEPT 1968, 19....., at 8:30 m., and WAS NOT (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 ABRASION TO UPPER RT FOREARM

Hospitalized NO 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

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)*
COLLINS, MARTIN

2. DATE OF THIS NOTICE *(Mo., day, yr.)*
4 SEPTEMBER 1968

3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*
USNS GEN. JOHN POPE (T-AP 118)
c/o FLEET POST OFFICE, SAN FRANCISCO, CALIFORNIA 96625

4. DATE OF INJURY *(Mo., day, yr.)*
4 SEPTEMBER 1968

5. OCCUPATION
BOATSWAIN

6. HOUR OF INJURY *(a.m. or p.m.)*
0800

7. PLACE OR LOCATION WHERE INJURY OCCURRED
PIER #2, BERTH # 32, SAN FRANCISCO NAVAL SHIPYARD (HUNTER'S POINT)

8. CAUSE OF INJURY *(Describe how and why injury occurred)*
EMPLOYEE WAS SUPERVISING ASSEMBLY OF LOADING RAMP AT AFTER PORT SIDEPORT, IN PREPERATION OF LOADING STORES. AS HE BACKED AWAY FROM RAMP, HE STEPPED INTO AN OPENING IN THE DECK OF THE PIER THAT CONTAINS CONNECTIONS FOR STEAM AND WATER. THIS OPENING HAS NO SAFETY CHAIN GUARDING IN ON THE SIDE FACING THE SHIP.

9. NATURE OF INJURY *(Name part of body affected—fractured left leg, bruised right thumb, etc.)*
ABRASION ON UPPER, INSIDE OF RIGHT FOREARM, AND A SMALL SCRATCH ON OUTSIDE OF UPPER LEFT THIGH.

10. NAMES OF WITNESSES TO INJURY
POITIER, JOSEPH P. ART. NO. 573-7

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 abour 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
MARTIN COLLINS, BOATSWAIN

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

THE BOATSWAIN WAS HELPING TO SET UP A LOADING RAMP FROM THE PIER INTO THE AFTER PORT SIDEPORT IN PREPERATION OF LOADING STORES. HE STEPPED INTO A STEAM AND WATER SERVICE OPENING IN THE DECK OF THE PIER. THERE WAS NO SAFETY CHAIN GUARDING THE OPENING ON THE SIDE FACING THE SHIP. A LINE HAS NOW BEEN PLACED ACROSS THE OPENING TO PREVENT SUCH AN ACCIDENT FROM HAPPENING AGAIN.

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*
Wm Purchase WILLIAM PURCHASE, ACTING FIRST OFFICER	4 SEPTEMBER 1968

19. STATEMENT OF WITNESS

THE BOATSWAIN WAS HELPING TO SET UP THE LOADING RAMP AT THE AFTER SIDEPORT. HE WAS STANDING ON THE PIER, AND WHEN HE BACKED UP, HE FELL THROUGH A HOLE IN THE DECK OF THE PIER. THERE WAS NO SAFETY CHAIN ON THE SIDE OF THE HOLE WHERE HE FELL.

20. SIGNATURE OF WITNESS	21. DATE *(Mo., day, yr.)*
JOSEPH P. POITIER, STEWARD UTILITYMAN	4 SEPTEMBER 1968

22. STATEMENT OF WITNESS

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

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