Approved For Release 2000/08/16 : CIA-RDR20-06679A000100010111-3

Security Information

27 February 1953

OPM 20-620-1 PERSONNEL DIRECTOR PERORANDUM NO. 12-53

SUBJECT: Leterim Instruction - Compensation for Injury or Death

The attached interim instruction on compensation for injury or death incurred in the performance of duty is issued pending publication of an Agency Regulation on this subject. This is the first of a series of such instructions to be published in the next few weeks, Internal procedures of the Personnel Office will conform to those instructions immediately upon issuance. Upon publication as an Agency Regulation the attached material will supersede the present CIA Regulation

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2. Information copies of this instruction will be distributed to other interested offices of the Agency. Comments or suggestions of these offices are invited in order that they may be considered in the preparation of the Regulation. Offices receiving information copies are being asked to forward their comments to the Personnel Office, attn: Research and Planning Staff, by 23 March 1953.

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CEORGE E. MELOON Personnel Director

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Compensation for Injury or Death

l. Policy

Raployees of the Central Intelligence Agency are entitled to compensation bedefits under the Federal Employees' Compensation Act (Public law 267, 64th Congress) as amended and/or the Central Intelligence Agency Act of 1949 (Public Law 110, 81st Congress) as amended. These benefits include compensation for disability and death, and medical care for employees who suffer injuries in the performance of their duties.

2. Definitions

a. "In the Performance of Inty"

"In the performance of duty", as used in this Instruction, means that the individual's injury is directly attributable to or materially aggravated by his work and is not the result of the employee's willful misconduct, intexication, or intention to bring about the injury or death of himself or another.

b. *Injury®

For the purposes of this Instruction, the term "injury" includes, in addition to injury by accident, any disease proximately caused by the employment of the individual.

3. Command

- a. Federal Employees Compensation Act
 - (1) The provisions of the Federal Employees Compensation Act apply to employees of the Central Intelligence Agency who are citizens or residents of the United States or a territory of the United States.
 - (2) Employees of the Central Intelligence Agency who are neither citizens nor residents of the United States nor a territory of the United States will be compensated substantially in accordance with the benefit provisions of local workmen's compensation laws and regulations as recognized by the United States Eureau of Employees' Compensation.
- b. Central Intelligence Agency Act of 1949

Employees otherwise eligible for benefits under the Federal Compensation act whose claims may not be submitted to the Bureau of Employees!

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Approved For Release 2000/08/16 ACIA-RDP30-0679A000100010111-3

INTERIL INSTRUCTION

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Compensation for security reasons will be granted these benefits under the authority contained in Section 10 of the Central Intelligence Agency Act of 1949.

4. Responsibilities

- The Assistant Director (Personnel) is responsible for the administration of this program, for prescribing necessary procedures and for coordinating activities of other offices responsible for the performance of related functions. He, or his designee, will determine whether claims are to be processed under the provisions of the Federal Employees' Compensation Act or the Central Intelligence Agency Act and will administratively approve or disapprove those processed under the latter Act.
- b. The Office Chief concerned, the Chief, Medical Staff, the General Counsel and the Security Officer, CIA, are responsible for providing such recommendations concerning medical, legal or security issues involved in determining the method of processing or the compensability of individual claims as are requested by the Assistant Director (Personnel), or his designee.
- c. Supervisory officials are responsible for furnishing such documents, records and information as may be requested.
- d. Employees who claim benefits are responsible for complying with the procedural requirements set forth below and for fulfilling such other requests for information and examinations as may be necessary.

5. Denofita

a. General

Information and advice as to benefits in specific cases will be provided by the Personnel Office upon request. The general benefits to which employees may be entitled are listed in Appendix A. Briefly they include the following:

- (1) Payment for medical services and supplies, regardless of whether the injury has resulted in loss of worktime.
- (2) Loss of income benefits based upon time lost from work and upon the nature of disability or disfigurement.
- (3) Allowance for the services of an attendant for totally disabled persons.

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Approved For Release 2000/08/16 CIA-RDB80-00679A000100010111-3

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- (h) Allowance for vocational rehabilitation of permanently disabled parsons.
- (5) Death benefits based on the employee's monthly pay and the number and relationship of his dependents.
- (6) Allowance for funeral expenses, under certain circumstances.
- b. Weiting Period

Employees are not entitled to compensation for loss of pay for the first three days of disability unless the period of disability exceeds 21 days or is permanent.

e. Use of Sick or Amual Leave

If the employee so elects, sick and/or annual leave or leave without pay may be utilized during the period of disability. In such cases, compensation payments will become effective upon termination of leave.

d. Alternative Benefits

An employees who is entitled to compensation benefits under the Federal Employees' Compensation Act, as amended, or the CIA Act, as applicable, may also qualify for other benefits. For example, an employee eligible for compensation benefits may also be eligible for a disability annuity under the Civil Service Retirement Act. An employee who is eligible for alternative benefits shall elect which of the benefits he will receive for the period the benefits are available.

6. Treatment

- a. Madical treatment of an employee injured in the performance of duty will be exranged by his supervisor as follows:
 - (1) Personnel stationed in Washington will be referred to the Agency Madical Office.
 - Personnel of a U. S. field station cutside Washington will be referred to the local CIA medical officer, if one is available. Otherwise, if security considerations permit, they will be referred to the nearest U. S. Covernment medical facility or physician designated by the Bureau of Employees: Compensation, when available. If neither a local CIA medical officer nor a wailable. If neither a local CIA medical officer nor a U. S. Covernment medical facility nor a designated physician can be used, the Chief, Fedical Staff, will be contacted for instructions or, in an emergency case, treatment may be obtained

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INTERIM INSTRUCTION

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- Any injury incurred in the performance of duty which disables or is likely to disable an employee will be reported by the supervisor of the employee concerned on Form C. A. 2, Official Superior's Report of Injury. (Sample copy of Form C. A. 2 is included in Appendix B.) This form will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels. When treatment has not been furnished by the Agency Medical Office, the supervisor will arrange for completion of the Government Medical Officer's statement on the reverse side of Form C. A. 2, if applicable, unless security considerations preclude furnishing this information.
- c. Termination of disability of an injured employee will be reported by his supervisor on Form C. A. 3 (upper portion), Report of Termination of Total or Partial Disability, unless it has previously been reported on Form C. A. 2, Official Superior's Report of Injury. Form C. A. 3 will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels.
- Death of an employee as a result of an injury incurred in the performance of duty will be promptly reported by the employee's supervisor on Form C. A. 3 (lower portion), Report of Death. Form C. A. 3 will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels.

8. Claims

- An employee injured in the performance of duty will make claim for reimbursement or payment of the cost of medical services and supplies and for compensation for loss of pay on Form C. A. L. Claim for Compensation on Account of Injury. (Sample copy of Form C. A. L. is included in Appendix B.) Form C. A. L. will be prepared in duplicate within 60 days from the date of injury. Documents in support of the claim, including all itemized bills and receipts, travel orders and claims for personal expenditures by the individual, will accompany Form C. A. L. The Attending Physician's Certificate on the reverse side of Form C. A. L. will be obtained if security considerations permit. The supervisor of the injured employee will complete the Certificate of Official Superior of Injured Employee on the reverse side of Form C. A. L. Completed forms will be forwarded to the Personnel Office through appropriate administrative channels.
- to Claim for compensation benefits by the survivor(s) of an employee who dies as the result of an injury incurred in the performance of duty will be made on Form C. A. 5, Claim for Compensation on Account of Death. Form C. A. 5 will be submitted to the Personnel Office in duplicate.

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Approved For Release 2000/08/16 1 C A RDP80-006/79 A 00100010111-3

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- Claim for reimbursement of travel expense incident to securing treatment (see paragraphs 6 c and 6 d above) will be made on Standard Form No. 1012, Voucher for Per Dien and/or Reimbursement of Expenses Incident to Official Travel. This claim will be submitted to the Personnel Office through appropriate administrative channels.
- the Assistant Director (Personnel) or his designee will review each claim to determine shether it is to be processed under the provisions of the Pederal Employees' Compensation Act or the Central Intelligence Agency Act.
 - (1) Claims processed under the Federal Employees Compensation Act will be forwarded by the Personnel Office to the Bureau of Employees Compensation for adjudication, on a classified or unclassified basis as the situation warrants.
 - (2) Claims processed under the Central Intelligence Agency Act will be administratively approved or disapproved by the Assistant Director (Personnel) or his designee.
 - (a) Approved claims will be forwarded to the Finance Division for payment.
 - (b) Disapproved claims will be returned to the claimant with a manorandum stating the reasons for disapproval. A copy of this memorandum will be forwarded to the Office Chief concernsd.

Approved For Release 2000/08/16 : CIA-RDP80-0067974000100010111-3

APPENDIX A

COMPENSATION BENEFITS

Approved For Release 2000/08/16 : CIA-RDP80-00679A000100010111-3

COMPENSATION BENEFITS

	en e	QUALIFICATIONS	AMOUNT	
x 100 CT	Hospital and madical expanses	If approved facilities used and procedures followed	Varies with case	
Ž,	Travel to place of tresiment	If local facilities are not switable or available	Varies with case	
. Fo	Services of an attendant	If necessary because employee is so helpless as to require constant attention	Not to exceed \$75 per month	
ho	Compensation for time lost	If desired. May take accrued sick and annual leave	66 2/3% of monthly salary or schedule award	
E a	Augmented compansation for dependents	If one or more dependents. Relationship: Wife, Husband, Unmarried child, Dependent Parent	8 1/3% of monthly pay (limited to that part of monthly pay not in excess of \$120)	
6.	Funeral bills	If death results from the injury	Discretionary. Not to exceed \$4,00	
19 5-9	Death Benefits			
	a. Widow	a. Until remarriage or death	a. 15%	
	b. Wideser	 b. If wholly dependent upon wife. ('Til remarriage, death or capable of self- support) 	b. 45%	
	c. Children	e. Til child marries, dies, or reaches 18	c. To widow 40%, and 15% for each child not to exceed 75%	
	d. Orphen children	d. Same as c	d. 35% for one child and 15% for each ad- ditional child not to exceed 75% divided among such children share and share alike	
	e. Dependent Parent	e. (1) If one dependent and	e. (1) 25%	
		(2) If both are dependent	(2) 20% to each	
	f. Other dependents	f. (1) If one dependent (2) If more than one (3) If one wholly dependent but one or more only partially dependent	f. (1) 25% (2) 30% share alike (3) 10% share alike	

APPENDIX B

SAMPLE FORMS

Approved For Release 2000/08/16: CIA-RDP80-00679A060100010111-3

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the U. S. DEPARTMENT OF LABOR, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

3. Nature of injury		Date of this notice, 19
and on	1.	I hereby certify that I am employed as a
I was injured in the performance of my duties at		(Occupation)
I was injured in the performance of my duties at		(Place of employment)
I was injured in the performance of my duties at		and on,
2. Cause of injury		I was injured in the performance of my duties at
2. Cause of injury (Describe as best you can how and why injury occurred) (Name part of body affected—fractured left leg. bruised right thumb, etc.) 4. Names of witnesses to injury (Name part of body affected—fractured left leg. bruised right thumb, etc.) 5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when (This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me. Name		(Location where injury occurred)
3. Nature of injury	2.	
3. Nature of injury		
4. Names of witnesses to injury 5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me. Name		
4. Names of witnesses to injury	3.	
5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me. Name	4.	Names of witnesses to injury
This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me. Name	5.	
This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me. Name		of person to whom notice was first given, and when
	my tre	This injury was not caused by my willful misconduct, intention to bring about the injury or death of vself or of another, nor by my intoxication, and I hereby make claim for compensation and medical
		Name
(Street and number)		
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[To be submitted to U.S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., 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	1.	Department 2. Bureau or office
employment	3.	. Place of employment, (City) (State)
	4. 5	. Reporting office (Location of reporting office or division headquarters)
		Name of superintendent or foreman in charge when injury occurred
	6.	. Name of injured employee 7. Age 8. Sex 9. Race
	10.	Home address (Street and number) (City or town) (State) Occupation and division 12 Was amployed doing his regular
	11.	(Give both, as laborer, hull division; helper, machine shop, etc.)
		work: If not, what work?
The injured		Total length of service with the Government as a civilian?
employee		. How long at present work in this establishment?
	15.	Dates of other injuries
	16.	Rate of pay on date of injury, \$ per and subsistence valued at \$ per
		and quarters valued at \$ per
	17.	Employee begins work at
	19.	Hours worked per day 20. Days paid per week
	21.	Place where injury occurred(Give exact location, as name or number of building and division, etc.)
	22.	Date of injury; hour of day m.
		Date employee stopped work, 19; day of week; hour of day m,
	24.	. Date employee's pay stopped, 19; day of week; hour of day, m,
	25.	. Has employee returned to work? (a.m. or p. m.) (Give date and hour)
	26.	Will employee receive pay for any portion of above absence on account of:
		(a) Annual leave
		(b) Sick leave(Give exact dates)
	0.77	(c) Any other reason (Give exact dates) (Give exact dates)
	27.	Describe in full how injury occurred
The injury	29.	State part of body injured and nature and extent of injury Did injury cause loss of any member or part of member? If so, describe exactly Was employee injured while in performance of duty? If not, or in doubt, give detailed statement
	81.	Was injury caused by: (a) Willful misconduct of the employee?
	00	of himself or another? (c) Employee's intoxication? (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.)
	3Z.	Was written notice of injury given within 48 hours? If not, did immediate superior have actual
	99	knowledge of injury?
	oo.	Names and addresses of witnesses to injury
	84.	(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form) Was injury caused by a third party other than a Government employee or agency?
	04.	•
		employee been instructed in procedure under the Bureau's regulations? (A detailed statement should be forwarded with this report)
	35.	Name and address of physician who first attended case
Medical		How soon after injury?
1		To what hospital sent? Location
		Name and address of physician now attending case
		day of, 19(Signature of reporting officer)
at		(Title)

Approved For Release 2000/08/16 : CIA-RDP80-00679A000100010111-3

STATEMENT OF WITNESSES

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I CERTIFY thatability will be	OF GOVERN	(Name of emp 19, at	DICAL OFFICAMINED CAS	CER OR PHYSICIAN WHO was given first-aid treatment, or was given first-aid treatment, or craves acti.	examine e length e to inju
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I CERTIFY that	OF GOVERN	(Name of emp 19, at	DICAL OFFI	CER OR PHYSICIAN WHO E was given first-aid treatment, or disabled for work. Probable or work opinion disability (Was or was not) when there treatment (Was or was not)	examine e length
I CERTIFY that	OF GOVERN	(Name of emp. 19, at	DICAL OFFI	CER OR PHYSICIAN WHO E was given first-aid treatment, or	e examine

Approved For Release 2000/08/16 : CIA-RDP80-60679A000100010111-3

CLAIM FOR COMPENSATION ON ACCOUNT OF INJURY

[To be filed with the official superior, within 60 days after the injury causing disability for more than 3 days, for transmission to the U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION]

CLAIM MUST BE FILED WITHIN ONE YEAR AFTER INJURY

Mame of injured employee Cities fore seems in full Chapter towns Cities fore seems in full Cities fore seems in full Cities fore seems in full Cities fore seems Cities for seems Cities fore seems Cities seems Cities fore seems Cities fore seems Cities fore seems Cities fore seems Cities seems Cities fore seems Cities	Section 39 of the Compensation Act of September 7, 1916, prov ment, knowing it to be false, shall be guilty of perjury and shall for not more than one year, or by both such fine and imprisonment	2. Age 3. Sex
Rate of pay when injured, \$ (a) Were subsistence and quarters furnished by the United States? (b) If so was their value deducted from pay? (c) In either case, state value: Subsistence, \$ per ; quarters, \$ per ; quarte	[Give first name in full]	
Rate of pay when injured, \$ (a) Were subsistence and quarters furnished by the United States? (b) If so (c) Were they received in addition to rate of pay? (b) If so (c) In either case, state value (subsistence, \$ per ; quarters, \$ per ; quarters, \$ per Time of injury 19 [Dow of week] [Howe a. no. or p. no. o	Iail address[Street and number]	[State] Occupation and division
(a) Were subsistence and quarters furnished by see they received in addition to rate of pay? (b) If so or was their value deducted from pay? (c) In either case, state value: Subsistence, \$ per ; quarters, \$ per Time of injury was their value deducted from pay? (c) In either case, state value: Subsistence, \$ per ; quarters, \$ per Disability for work began Dates 19 Dav of week) How as the per First able to resume usual occupation Dates 19 Dav of week) How as the per First able to resume usual occupation Dates 10 Date of the per First able to resume usual occupation Dates Total amount, \$ Period for which compensation is claimed. From Period for which compensation is claimed. From Period for which compensation Dates Total amount, \$ Specify any other reason Dates Total amount, \$ Specify any other reason Dates Total amount, \$ Have you worked for anyone during the period of disability? If so, give name and address employer, dates worked, rate of pay, and total amount earned Were you furnished subsistence or quarters, (other than in hospital) during period of disability? If so, give dates on which subsistence or quarters, or both, were furnished If medical, surgical, or hospital service was furnished by private physicians or hospitals, state amount expense incurred, \$ reason for not using United States medical officers or hospitals if a favailable. If transportation and other expenses necessary to enable you to secure proper medical and hospital tre ment were incurred by you, state amount of expense so incurred, \$ If reimbursement ment were incurred by you, state amount of expense so incurred, \$ If reimbursement If reimbursement If transportation and other expenses necessary to enable you to secure proper medical and hospital tre ment were incurred by you, state amount of expense so incurred, \$ If you have received any money in payment of damages on account of the injury described above? If you have	Married, single, widowed. 6. Race	Occupation and arrangement
(a) Were subsistence and quatrers furnished and set of pay? (b) If so or was their value deducted from pay? (c) In either case, state value: Subsistence, \$ per ; quarters, \$ per Time of injury [Date] 19	Rate of pay when injured, \$per	itad States?
(b) If so was their value deducted from pay? (c) In either case, state value: Subsistence, \$ per	() Word gubaistance and dilarters lurinshed by the On	ica States :
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(c) In either case, state value: Subsistence, s. per		· · · · · · · · · · · · · · · · · · ·
Time of injury Disability for work began Disability Disability Disability for work began Disability Disability for work began Disability Disabil	(c) In either case, state value: Subsistence, \$I	per; quarters, \$ per
Have you received any pay from the down or sick leave Dates On account of annual or sick leave Dates Specify any other reason Dates Total amount, \$. Specify any other reason Dates Total amount, \$. Total amount, \$. Specify any other reason Dates Total amount, \$. Total amount, \$. Specify any other reason On account of disability? If so, give name and address employer, dates worked, rate of pay, and total amount earned Specify any other reason for any other pays and total amount earned Specify of the specific of the specifi	Pime of injury	, 19 [Hour a. m. or p. m.]
Have you received any pay from the Government of annual or sick leave Dates Total amount, \$. Specify any other reason Dates Total amount, \$. Total amount, \$. Specify any other reason Dates Total amount, \$. Tota	Dischility for work heran	, 19 [Hour a. m. or n. m.]
Have you received any pay from the Government of annual or sick leave Dates Total amount, \$. Specify any other reason Dates Total amount, \$. Total amount, \$. Specify any other reason Dates Total amount, \$. Tota	Disability for work began[Date]	, 19 [How as more 1]
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Spectry any other reason Have you worked for anyone during the period of disability? Have you worked for anyone during the period of disability? Were you furnished subsistence or quarters (other than in hospital) during period of disability? If so, give dates on which subsistence or quarters, or both, were furnished If medical, surgical, or hospital service was furnished by private physicians or hospitals, state amount expense incurred, \$\(\) network and submit an itemized bill for this service with an explanation reason for not using United States medical officers or hospitals, if available. If transportation and other expenses necessary to enable you to secure proper medical and hospital tre ment were incurred by you, state amount of expense so incurred, \$\(\) If reimbursement period along the expenses. [Give dates, places of travel, and amount poils, along any special expenses uncounty, \$\(\) If reimbursement period along the expenses. [Give dates, places of travel, and amount poils, along any special expenses uncounty, \$\(\) If reimbursement, and additional poils, and any period expenses uncounty, \$\(\) Place where injury occurred [Give cause the injury occurred for the injury described above in the property of the property of the injury described above? If you have received any money in payment of damages, state amount, \$\(\) Nature and extent of injury causing disability If you have received any money in payment of damages, state amount, \$\(\) Nature and extent of injury causing disability If you have received any money in payment of damages, state amount, \$\(\) Nature and extent of injury causing disability If you have received any money in payment of damages, state amount, \$\(\) Nature and extent of injury or naval service? If so, give details If you have received any money in payment of damages, state amount, \$\(\) Nature and extent of injury or payment of damages, state amount, \$\(\) Nature any exception of the injury of payment of the injury of payment of the payment of the	Have you received any pay from the dovernment daring	Total amount. \$
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ATTENDING PHYSICIAN'S CERTIFICATE AND MEDICAL REPORT OF DISABILITY Approved For Release 2000/08/16: CIA-RDP80-00679A000100010111-3

	I CERTIFY that	[Name of	injured employee1			professional care from
		to		, inclusi	ve, for the effects o	f injuries sustained or

3	In my opinion, employee in partially disabled for usua					
and	Bationt [was] ablate	o resume regular wo				
	may be able to	resume regular wor	rk	*******************		
	Patient \ \begin{pmass} \text{was} \\ \text{may be} \end{pmass} able to	resume light work		·		
1.	Dates of treatment visits:	(a) Office		*		
	(b) HomeNature of treatment provi		f	(c) Hospital		
2.	Nature of treatment provi					
٠.	(a) Operation	1.10	4.4	(b) Date	performed	
3.	Specify special services				* *	
						•
4.	State what history of injur	y was given by emp	loyee			
Б.	Describe the symptoms or					
5. .	Describe the symptoms of	physical indings it	or which treatme	nt was given	ja na sanah	
	and the second of the second o	and the second of the second o				
	(a) X-ray—laboratory—	-specialist's reports				
6.	State how your findings co	nfirm your opinion	that the disabilit	y was due to injury		
		and the second s				
7.	Describe complicating and					
	Employee was confined (a)					
9.	Are permanent effects of t	the injury probable?	?	Describe in detail		
		,			4, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	
anın	Note.—In all cases where ition to an alleged injury clinical course of the cond to an injury. I am licensed to practice					
	juka u€ggara	organization of the state of th	Alexander Services	Control of the	Mary to a control	
		Magainese and		[S	ignature of attending pl	iysician]
	Signed this					
. 4 .	in the second of	ing design of the second of th	in the property of the second	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		And the second second
	Street Street	eet and number]			[City and State]	
	TOOL OWN . HOUR	A columnia to	•	-		A Commence of the Commence of
	CERT	IFICATE OF OF	FICIAL SUPE	RIOR OF INJU	RED EMPLOYE	E
	[Report of injury	(Form C. A. 2) if no	ot heretofore forw	arded to the Bureau	, should accompany	this claim.
	If any circumstance the official superior disa explanatory statement b	s have arisen which	alter the conclus	sions stated in the of	ficial report of injur	y (Form C. A. 2), or i
	the official superior disa explanatory statement b	grees with any of the e made under "Rema	he statements ma arks."	ide in the claim for	compensation, it is	requested that a ful
1. I	the injured employee is a	piece worker or an i	irregular worker.	what were his grow	ss earnings during i	the month immediately
	preceding the injury? \$	and the second and the second	; actual dates of	n which he worked	C	
2. H	as employee resumed worl	ee was injured on the ri	f so, give date a	oss earnings snould be gr ad hour	ven for January 7 to re	ruary 6, inclusive]
3. H	as employee been paid for	any portion of the a	absence for which	compensation is cla	imed?	If so, state inclusive
	datos	epp will be a sum				
	(\$200 C 15.1% (44.63) 10 500	- 8 : 9 				
	emarks	The Mark State of the Control of the		<u> 11 gy M. 480 (1851)</u> 1861 - Albania	K munaci	
4. R	emarks		ere e ja			
of h	I HEREBY CERTIFY that the is duty for the United Sta report are true to the bes					
1200	Service Service Control of the Contr	o o o o o o o o o o o o o o o o o o o	n en oppositier in de de Benedigter 2, et de	in the second	en garantza eta eta eta eta eta eta eta eta eta et	na in
	Signed this	day of		19		
r ·	ANTHAMAS CONTRACTOR	-114 Dist. 9()11	a de la composition della comp	iliaa fiyo sa ah m	Tie	le]
	at	TEUB COME	. s. Government PRINTING O	Price 16—11488-1	n Branka	=

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APPENDIE C

LIST OF FORMS

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FORTS USED IN REPORTING INJURIES, PROCESSING CLATIE, AND FILING APPEALS

Listed below are the forms required in injury and death cases under the United States Amployees' Compensation Act of 1916, as amended. This list identifies the title of each form and indicates by whom and when each form should be submitted. Non-esterisked forms are obtained from the Personnel Uffice. Forms indicated by one asterisk are furnished direct to claiments by the Person, those indicated by two asterisks are furnished only to hespitals and physicians.

	And A b Vi	To be submitted.	tiku, singkalan kating turukuluku. Siga di milangkulikulus (se amak) 700 di dapunta superindak di milangkara sa Biga
POITS	Htle	8 7° a	to Behaves
Co Ac L	Employee's Notice of Injury or Ge- cupstional Dis-	imployer (or someone acting in his behalf).	after injury as is practicable. Form filed in employee's personnel folder in since injury cases not recerted to the Jareau.
Go Ac 2	Manager Co. Manager	imployee's supervisor	Same as form C. A. 1, if injury results in disability for work beyond the day or shift of occurrence, or night result in any medical charge against the compensation And.
Go Ao 2	official Superior's Report of Injury, (To cover recurrence of disability from original injury.)	Exployee supervisor occo	Immediately when an injured employee is again cleabled from the same injury. Force should be marked "lecturence," and should contain sufficient facts to identify the injury. Here dates when work and pay stopped and part of the new
			should also be shown. If disability has suited when the report is made, the date and hour of return to duty should be shown; otherwise a new report on form 2. A. 3

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should be made when the enployee returns to work or

disability ceases.

Approved For Releas 2000/08/16 : CIA-RDP80-0(6) 9 300100010111-3

		To be submitted	
Fern	Tilla	Hymm	//penmen
C. 4. 3	Report of Termination of Total or Partial Disability: (Upper Fortion)	Employee's Superviews	return to work after dis- ability, unless such report has been made on form d. A. S. or otherwise.
Ge Ac 3	Report of Death (".ower Portion)	Pesignated official	Immediately, and to be accompanied by report on Form C. A. 2, if such form has not proviously been submitted.
Co As L	Claim for Compensation on Account of Injury	Exployee (or someone acting in his behalf).	Within 13 days after pay stope but not later than 50 days after injury. Explanation must accompany claim if sub- mitted later than 50 days after injury.
C. A. LA	Application for Augmented Compensation for Disability	Employee (or someone acting in his behalf).	Accompanies C. A. L when dependency benefits are claimed.
C. A. 48	Application for Award for Disfigurement.	Employee (or someone acting in his behalf).	Accompanies C. A. 4 in cases of disfigurement of face, head, or neck.
C. A. 5	Claim for Compensation on Account of Death.	Beneficiary	As soon as possible after death, but not later than 1 year.
Co Ao 5A	Application for Balance of Schedule Due them Death is From Causes Other than the Dijury.	Reneficiary	within I month after death and not later than I year.
C. A. 8	Claim for Continu- ance of Compensation on Account of dis- ability.	Employee (or someone acting in his behalf).	At least once a month.
C. A. 10	Flacard for Posting		
C. A. 11	Famphlet Containing Resume of Employee's Rights to Componsa- tion Benefits.		

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Approved For Release 2000/08/16 : CIA-RDP80-00679A000100010111-3

			To be submitted-	τ ρ
r uran aurum	Zorm -	Title	Byen	When
**************************************	A. 12	Claim of Midow or Midower for Continued Compensation on Ac- count of Death.	Widow or widower or guard ian on behalf of such beneficiary if mentally incompetent	- On the 1st day of January and July of each year while the compensation continues.
THE A	A. 13	Chaim of Guardian of Minor Children for Continued Compensa- tion on Account of Heath.	legal nor natural guard- ian or guardian ex offici on behalf of a minor or mentally incapacitated beneficiary other than widows, widowers, par- ents, or grandparents,	
#G.	A. 13A	Claim for Continued Compensation on Ac- Count of Death by Dependent Physically Incapable of Self- Support.	Incapacitated benefici- aries other than widows, widowers, parents, or grandparents who are not minors and have no guardian.	Same as Form C. A. 12.
AG o	Ac 14	Request of Dependent Parents or Grandpar- ents for Additional Compensation on As- count of Death.	Dependent parents or grandparents.	Sama as Form C. A. 12.
Co	A. 16	Request for Treatment of Injury Under the United States Employ- ees' Compensation Act. (Request for treatment by non-designated phy- sician will be issued in letter form.)	Employee's supervisor or Medical Officer.	Immediately after the accident, if practicable. Authorization for emergency treatment may be given before issuance of this form, provided it is issued within he hours thereafter.
C.	A. 17	Request for Treatment of Injury Under the United States Employees Compensation Act When C of Injury is in Doubt (Same as Form C. A. 16.	80.30	Immediately in order that it can be forwarded to proper office for necessary action.
	. A. 20	Attending Physician's Report.	Attending physician	As soon as possible.
	. A. 21	Discharge Report of Injury Case.	Hospital, dispensary, or designated physician.	When patient is discharged.

Approved For Release 2000/08/16 : CIA-RDP80-00679A 20100010111-3

		To be submitted	
PORTS	The state of the s	Byes	When==
Vo 40 32	Report of Hernia	Claimant and attending physician	As soon as possible.
∞. A. 33	Request (by Sureau) for Redical Exemina- tion.	Bureau	As deemed necessary
16. 40 42	Affidavit Relating to Representatives of Deceased Bene- ficiaries.	Any person having know- ledge of the funeral and burial expenses other than the undertaker or a member of his establish- ment. (This form is used when there is no adminis- tration of the deceased employee's estate in claiming burial allow- ance or compensation due the deceased employee at the time of his death.)	As soon as possible after burnal of deceased employee.
C. A. 43	Affidavit of Undertaker	Undertaking establishment	As soon as possible after burial of deceased employee.
C. A. 69	Employee's Claim for Continuance of Compensation on Account of Dis- ability When Case Is Carried on Auto- matic Rella	Employee	In lieu of C. A. 8
C. A. 76	list of Physicians and Hospitals Approved by Bureau Which Are Available to Injured Employees.		
C. A. 83	imployee's Motice of Compensation Payment by Bureau.	Bureau	
G. A. 86	Official Superior's Notice of Compensa- tion Payment by Suresu.	Bureau	
G., A. 95	Employee's Claim for Continuance of Con-	Exployee	In lieu of C. A. 8 when medical evidence is not

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		To be submitted	Baranta da antigo de la composição de porte de la composição de la composição de la composição de la composição
FOID	TLOS	Bytes as	\hen-
0. A. 96	Employee's Affidavit Disclosing Earnings, if any, During Disability.	Employee (par- tially disabled)	As requested by Bureau.
*G-1	Agreement of Claimant	Claimant (or attorney authorized to act in his behalf).	Upon approval of Claimant's attorney by the Eureau.
##S= 6 9	Public Voucher for Services and Supplies of Hospitals and Physicians.	Injured employee, physicians, nurses, hospitals, and any person or firm furnishing supplies or services for medical and allied expenses. If signature of employee cannot be obtained, a concise explanation of the reason must be included.	ment extends for more than 30 days, in which event it
Standard Form 1012,	Voucher for Per Diem and/or Reim- bursement of Ex- penses Incident to Official Travel.	Injured employee	When travel is completed, or if repeated trips are made, as often as convenient in accordance with Standard United States Government Travel Regulations.
*Standard Form 1034.	Public Voucher for Rurchases and Services Other Than Rersonal.	Undertaking establishment or person or firm furnish- ing services in connection with funeral or burial expenses of deceased employee.	As soon as possible after -burial of deceased employee.
AB-1	Application for Review	Ferson affected by Bureau decision.	is within 90 days after issuance of final decision by Bureau. Time limit may be waived by Board in extenuating cases, provided application is filed within lyear.