

# OCCUPATIONAL INJURY - MSFC CIVIL SERVICE ONLY

## INJURY DATA (Completed by MSFC Medical Center)

<p>1. Installation DOL Code..... <span style="border: 1px solid black; padding: 2px;">1</span> <span style="border: 1px solid black; padding: 2px;">7</span> <span style="border: 1px solid black; padding: 2px;">8</span> <span style="border: 1px solid black; padding: 2px;">7</span></p> <p>2. Name (Last, first, middle initial), mail code and phone number:          _____          _____          _____</p> <p>3. Social Security No. <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span></p> <p>4. Date, time and place of injury:          _____</p> <p>5. Sex (check): <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>6. Age..... <span style="border: 1px solid black; padding: 2px;">  </span> <span style="border: 1px solid black; padding: 2px;">  </span></p> <p>7. Category of injury (check):</p> <p style="padding-left: 20px;">a. Fatal..... <input type="checkbox"/></p> <p style="padding-left: 20px;">b. Non-fatal..... <input type="checkbox"/></p> <p>8. Supervisor's Name: _____          Mail Code: _____          Phone Number: _____</p> <p>Supervisor notified: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9. Circumstances of occurrence (one sentence or less of how it happened, such as slipped off curb and twisted ankle, etc.).          _____          _____          _____</p> <p>10. Occurrence in connection with TDY (check):</p> <p style="padding-left: 20px;">a. Injury occurred during official duties while on TDY..... <input type="checkbox"/></p> <p style="padding-left: 40px;">TDY Location: _____</p> <p style="padding-left: 40px;">Medical Facility: _____</p> <p style="padding-left: 20px;">b. Injury occurred while not performing official business on TDY..... <input type="checkbox"/></p> <p>11. Disposition (check as applicable):</p> <p style="padding-left: 20px;">a. Duty..... <input type="checkbox"/></p> <p style="padding-left: 20px;">b. Further diagnosis and/or treatment..... <input type="checkbox"/></p> <p style="padding-left: 20px;">c. Hospital..... <input type="checkbox"/></p> <p style="padding-left: 20px;">d. Home..... <input type="checkbox"/></p> <p style="padding-left: 20px;">e. Ambulance used..... <input type="checkbox"/></p>
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12. Doctor visited:	13. Date:
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**CLAIM DATE (Completed by Claims Officer if CA-1 submitted to DOL)**

<p>14. Date CA-1 submitted to OWCP:</p>	<p>15. CA-16 and CA-17 completed by NASA and submitted with CA-1:</p> <p style="padding-left: 20px;"><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No</p>	<p>16. Controverted COP:</p> <p style="padding-left: 20px;"><input type="checkbox"/> a. Yes (Explain in no. 20)</p> <p style="padding-left: 20px;"><input type="checkbox"/> b. No</p>
<p>17. One or more days lost (Exclude day of injury):</p> <p style="padding-left: 20px;"><input type="checkbox"/> a. Yes (Explain in no. 20)</p> <p style="padding-left: 20px;"><input type="checkbox"/> b. No</p>	<p>18. Injury caused by third party:</p> <p style="padding-left: 20px;"><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No</p>	<p>19. Light duty documented:</p> <p style="padding-left: 20px;"><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No</p>

20. Explanations and remarks (precede with item number):