CERTIFICATE OF WORK INCURRED INJURY OR DISABILITY

For use of this form, see AR 190-8; the proponent agency is PMG.

FROM:	DATE

TO:

SECTION I - TO BE COMPLETED BY INVESTIGATING OFFICER

NAME *(Last, first, MI)*			GRADE
INTERNMENT SERIAL NUMBER	**SERVICE NUMBER**	**NATIONALITY**	**POWER SERVED**
___ INJURY ___ DISEASE	**LABOR PERFORMED AT TIME OF INJURY OR WORK DISABILITY**		
PLACE WHERE INJURED		**TIME**	**DATE** *(Day, Month, Year)*

WITNESSES

CIRCUMSTANCES UNDER WHICH INJURY OR DISABILITY WAS INCURRED

In my opinion the injury to, or physical disability of, the EPW/Civ Internee named above ____ is ____ is not attributable to his/her work assignment.	**TYPED OR PRINTED NAME, GRADE AND ORIGINATION OF INVESTIGATING OFFICER**	
	SIGNATURE	**DATE**

SECTION II - TO BE COMPLETED BY MEDICAL OFFICER

STATEMENT OF MEDICAL TREATMENT AND HOSPITALIZATION

FINDINGS OF MEDICAL OFFICER

In my opinion the injury, or physical disability of the EPW/Civ Internee named above in Section I ____ was ____ was not attributable to his/her work assignment.	**TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER**	
	SIGNATURE	**DATE**