TITLE 8

ADMINISTRATIVE DIVISION

TITLE 8: ADMINISTRATIVE DIVISION

APPENDIX

FORM 1

Form No. DJ-64a
(Ed. 11-18-60)
(Formerly Form 5½ D.O.)
Form approved by
Comp. Gen., U.S.

ORIGINAL

DEPARTMENT OF JUSTICE
OFFICE OF THE UNITED STATES ATTORNEY
(District)
(Bureau or Division)

Bureau Vou. No. ....
Schedule No. ....

PAY VOUCHER FOR SPECIAL SERVICES

TO Richard Roe
(Name of payee)

Address 619 Monroe Road
(City and State)
(To which checks should be mailed)

	Period of Service	Rate Per	Amount: Dollars	Amount: Cents
	Days			
For SERVICES rendered as Special Assistant to the United States Attorney from February 18, 1962, to March 3, 1962, inclusive.	8	$25.	$200	00
On account of United States vs. Chrome et al. (State case or nature of business)				
REMARKS: Services were actually performed on the following dates: February 19, 21, 22, 23, 26, 27, 1962; March 1, 2, 1962. (Services were necessary on the holiday February 22.)				
APPROVED .... United States Attorney				

I CERTIFY that the above bill is correct and just and that payment has not been received.

(Sign original only)

Date .... Payee ....

Amount claimed.............. $..........
Less differences, (See attached).............. $..........
Employee withholdings, (See reverse).............. $..........
Approved for payment.............. $..........

I CERTIFY that the foregoing account is correct and proper for payment.

Date ...., 19...... ....
(Authorized Certifying Officer)

ACCOUNTING CLASSIFICATION (Appropriation Symbol must be shown; other classification optional)

U.S. GOVERNMENT PRINTING OFFICE

Title 8

Note:

The Page 152 was not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 2

STANDARD FORM 144
REVISED SEPTEMBER 1954
U. S. CIVIL SERVICE COMMISSION
FPM CHAPTERS L1, R1, AND S2

STATEMENT OF PRIOR FEDERAL CIVILIAN AND MILITARY SERVICE AND DETERMINATION OF COMPETITIVE STATUS

IMPORTANT: The information on this form will be used (1) in determining creditable service for leave purposes and retention credits for reduction in force, and (2) in recording agency determination of competitive status. The employee should complete Part I and the Personnel Office should complete Parts II through V.

PART I.—EMPLOYEE'S STATEMENT

1. NAME (*Last, first, middle initial*)

2. DATE OF BIRTH

3. LIST THE FOLLOWING INFORMATION CONCERNING ALL FEDERAL AND DISTRICT OF COLUMBIA SERVICE YOU HAVE HAD PRIOR TO YOUR PRESENT APPOINTMENT (*Do not include military service.*)

NAME AND LOCATION OF AGENCY	FROM—			TO—			TYPE OF APPOINTMENT IF KNOWN
	YEAR	MONTH	DAY	YEAR	MONTH	DAY	

4. LIST PERIODS OF ACTIVE SERVICE IN ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES. IF YOU HAD NO ACTIVE MILITARY SERVICE, WRITE "NONE."

BRANCH	FROM—			TO—			DISCHARGE (*Hon. or dishon.?*)
	YEAR	MONTH	DAY	YEAR	MONTH	DAY	

5. DURING PERIODS OF EMPLOYMENT SHOWN IN ITEM 3, DID YOU HAVE A TOTAL OF MORE THAN 6 MONTHS ABSENCE WITHOUT PAY, INCLUDING PERIODS OF MERCHANT MARINE SERVICE, DURING ANY ONE CALENDAR YEAR? ☐ YES ☐ NO
IF ANSWER IS "YES," LIST FOLLOWING INFORMATION.

TYPE IF KNOWN (*LWOP, Furl, Susp, AWOL, Mer Mar*)	FROM—			TO—			TOTAL		
	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEARS	MONTHS	DAYS

6. DURING THE FEDERAL SERVICE LISTED IN ITEM 3, DID YOU ACQUIRE A PERMANENT COMPETITIVE CIVIL SERVICE STATUS?
☐ YES ☐ NO
(*If answer is "Yes," in what agency were you employed at the time status was acquired?*)

7. ARE YOU:
A. THE WIFE OF A DISABLED VETERAN? ☐ YES ☐ NO
B. THE MOTHER OF A DECEASED OR DISABLED VETERAN? ☐ YES ☐ NO
C. THE UNREMARRIED WIDOW OF A VETERAN? ☐ YES ☐ NO

PART II.—THIS COLUMN IS FOR PERSONNEL OFFICE USE

9. RETENTION GROUP

10. A. CSC STATUS— ☐ YES ☐ NO
B. TYPE OF PRESENT APPOINTMENT

11. SERVICE

YEAR	MONTH	DAY

12. TOTAL SERVICE

13. NONCREDITABLE SERVICE (*Leave purposes only*):

14. NONCREDITABLE SERVICE (*RIF purposes only*):

15. REEMPLOYMENT RIGHTS
☐ YES ☐ NO

16. RETENTION RIGHTS
☐ YES ☐ NO

17. EXPIRATION DATE OF RETENTION RIGHTS

8. TO BE EXECUTED BEFORE A NOTARY PUBLIC OR OTHER PERSONS AUTHORIZED TO ADMINISTER OATHS.
I swear (or affirm) that the above statements are true to the best of my knowledge and belief.

______________________ (DATE)   ______________________ (SIGNATURE)

Subscribed and sworn to before me on this ____ day of ________ (MONTH) 19____ at ____________ (CITY) ________ (STATE)

SEAL   ______________________

NOTE: If oath is taken before a Notary Public, the date of expiration of his Commission should be shown.

INSTRUCTIONS: File this form on the permanent side of the employee's official personnel folder immediately before or after the personnel action involved.

FORM 2 (back)

Part III.—DETERMINATION OF COMPETITIVE STATUS. *(Complete for noncompetitive hires based on competitive status as required by instructions in FPM Chapter S2.)* Employee has a competitive status. This determination is based upon the following evidence:

NAME OF AGENCY	SIGNATURE AND OFFICIAL TITLE	DATE

PART IV.—DETERMINATION OF CREDITABLE SERVICE AND SERVICE COMPUTATION DATE FOR LEAVE PURPOSES

	TOTAL SERVICE *(Item 12)*	NONCREDITABLE SERVICE *(Item 13)*	CREDITABLE SERVICE *(Leave Purposes)*	ENTRANCE ON DUTY DATE *(Present Agency)*	LESS CREDITABLE - SERVICE *(Leave Purposes)*	SERVICE COMPUTATION DATE *(Leave Purposes)*
Years						
Months						
Days						

PART V.—DETERMINATION OF CREDITABLE SERVICE AND SERVICE COMPUTATION DATE FOR REDUCTION IN FORCE PURPOSES. *(Complete only in those cases when the amount of creditable service for reduction in force purposes differs from the amount creditable for leave purposes.)*

	TOTAL SERVICE *(Item 12)*	NONCREDITABLE SERVICE *(Item 14)*	CREDITABLE SERVICE *(RIF Purposes)*	ENTRANCE ON DUTY DATE *(Present Agency)*	LESS CREDITABLE SERVICE *(RIF Purposes)*	SERVICE COMPUTATION DATE[1] *(RIF Purposes)*
Years						
Months						
Days						

[1] Enter as the "Service Computation Date" on the employee's "Service Record Card," SF 7

REMARKS:

U. S. GOVERNMENT PRINTING OFFICE 16—[illegible]

FORM 3 (Year 1965)

LEAVE ACCRUAL CHART FOR 1965

No.	Period		Annual leave						Sick leave
	From	To	Adv***	Less than 3 years	Adv***	3 years but less than 15 years	Adv***	15 years or over	
1	Jan. 3, 1965	Jan. 16, 1965	100	4	154	6	200	8	4
2	Jan. 17, 1965	Jan. 30, 1965	96	8	148	12	192	16	8
3	Jan. 31, 1965	Feb. 12, 1965	92	12	142	18	184	24	12
4	Feb. 14, 1965	Feb. 27, 1965	88	16	136	24	176	32	16
5	Feb. 28, 1965	Mar. 13, 1965	84	20	130	30	168	40	20
6	Mar. 14, 1965	Mar. 27, 1965	80	24	124	36	160	48	24
7	Mar. 28, 1965	April 10, 1965	76	28	118	42	152	56	28
8	Apr. 11, 1965	Apr. 24, 1965	72	32	112	48	144	64	32
9	Apr. 25, 1965	May 8, 1965	68	36	106	54	136	72	36
10	May 9, 1965	May 22, 1965	64	40	100	60	128	80	40
11	May 23, 1965	June 5, 1965	60	44	94	66	120	88	44
12	June 6, 1965	June 19, 1965	56	48	88	72	112	96	48
13	June 20, 1965	July 3, 1965	52	52	82	78	104	104	52
14	July 4, 1965	July 17, 1965	48	56	76	84	96	112	56
15	July 18, 1965	July 31, 1965	44	60	70	90	88	120	60
16	Aug. 1, 1965	Aug. 14, 1965	40	64	64	96	80	128	64
17	Aug. 15, 1965	Aug. 28, 1965	36	68	58	102	72	136	68
18	Aug. 29, 1965	Sept. 11, 1965	32	72	52	108	64	144	72
19	Sept. 12, 1965	Sept. 25, 1965	28	76	46	114	56	152	76
20	Sept. 26, 1965	Oct. 9, 1965	24	80	40	120	48	160	80
21	Oct. 10, 1965	Oct. 23, 1965	20	84	34	126	40	168	84
22	Oct. 24, 1965	Nov. 6, 1965	16	88	28	132	32	176	88
23	Nov. 7, 1965	Nov. 20, 1965	12	92	22	138	24	184	92
24	Nov. 21, 1965	Dec. 4, 1965	8	96	16	144	16	192	96
25	Dec. 5, 1965	Dec. 18, 1965	4	100	10	**154	8	200	100
26	*Dec. 19, 1965	Jan. 1, 1966	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period.

*Leave year ends on 1-1-66. (Annual leave accumulation to be determined at close of this pay period.)

**10 hours earned last complete pay period in the calendar year for employees in this category.

***In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

FORM 3 (Year 1954)

LEAVE ACCRUAL CHART FOR 1954

PAY PERIOD			ANNUAL LEAVE			SICK LEAVE
			LESS THAN 3 YRS.	3 YRS. BUT LESS THAN 15 YRS.	15 YRS. OR OVER	
NO.	FROM	TO				
1	1/3/54 -	1/16/54	4	6	8	4
2	1/17 -	1/30	8	12	16	8
3	1/31 -	2/13	12	18	24	12
4	2/14 -	2/27	16	24	32	16
5	2/28 -	3/13	20	30	40	20
6	3/14 -	3/27	24	36	48	24
7	3/28 -	4/10	28	42	56	28
8	4/11 -	4/24	32	48	64	32
9	4/25 -	5/8	36	54	72	36
10	5/9 -	5/22	40	60	80	40
11	5/23 -	6/5	44	66	88	44
12	6/6 -	6/19	48	72	96	48
13	6/20 -	7/3	52	78	104	52
14	7/4 -	7/17	56	84	112	56
15	7/18 -	7/31	60	90	120	60
16	8/1 -	8/14	64	96	128	64
17	8/15 -	8/28	68	102	136	68
18	8/29 -	9/11	72	108	144	72
19	9/12 -	9/25	76	114	152	76
20	9/26 -	10/9	80	120	160	80
21	10/10 -	10/23	84	126	168	84
22	10/24 -	11/6	88	132	176	88
23	11/7 -	11/20	92	138	184	92
24	11/21 -	12/4	96	144	192	96
25	12/5 -	12/18	100	**154	200	100
26	*12/19 -	1/1/55	104	160	208	104

Annual leave accrues while in a pay status by pay periods only - no leave earned for any partial pay period.

*Leave year ends on 1/1/55 (Annual leave accumulation to be determined at close of this pay period.)

**10 hours earned last complete pay period for employees in this category each year.

FORM 3 (Year 1955)

LEAVE ACCRUAL CHART FOR 1955

NO.	PERIOD FROM	PERIOD TO	ANNUAL LEAVE: A D V	ANNUAL LEAVE: LESS THAN 3 YEARS	ANNUAL LEAVE: A D V	ANNUAL LEAVE: 3 YRS. BUT LESS THAN 15 YEARS	ANNUAL LEAVE: A D V	ANNUAL LEAVE: 15 YEARS OR OVER	SICK LEAVE
1	1-2-55	1-15-55	** 100	4	** 154	6	** 200	8	4
2	1-16	1-29	96	8	148	12	192	16	8
3	1-30	2-12	92	12	142	18	184	24	12
4	2-13	2-26	88	16	136	24	176	32	16
5	2-27	3-12	84	20	130	30	168	40	20
6	3-13	3-26	80	24	124	36	160	48	24
7	3-27	4-9	76	28	118	42	152	56	28
8	4-10	4-23	72	32	112	48	144	64	32
9	4-24	5-7	68	36	106	54	136	72	36
10	5-8	5-21	64	40	100	60	128	80	40
11	5-22	6-4	60	44	94	66	120	88	44
12	6-5	6-18	56	48	88	72	112	96	48
13	6-19	7-2	52	52	82	78	104	104	52
14	7-3	7-16	48	56	76	84	96	112	56
15	7-17	7-30	44	60	70	90	88	120	60
16	7-31	8-13	40	64	64	96	80	128	64
17	8-14	8-27	36	68	58	102	72	136	68
18	8-28	9-10	32	72	52	108	64	144	72
19	9-11	9-24	28	76	46	114	56	152	76
20	9-25	10-8	24	80	40	120	48	160	80
21	10-9	10-22	20	84	34	126	40	168	84
22	10-23	11-5	16	88	28	132	32	176	88
23	11-6	11-19	12	92	22	138	24	184	92
24	11-20	12-3	8	96	16	144	16	192	96
25	12-4	12-17	4	100	6	150	8	200	100
26	* 12-18	12-31-55	0	104	0	x* 160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only - no leave earned for any partial pay period.

* Leave year ends on 12-31-55. (Annual leave accumulation to be determined at close of this pay period).

x* 10 hours earned last complete pay period for employees in this category each year.

** In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

FORM 8 (Year 1956)

LEAVE ACCRUAL CHART FOR 1956

NO.	PERIOD FROM	TO	ANNUAL LEAVE A D V **	LESS THAN 3 YEARS	A D V **	3 YRS. BUT LESS THAN 15 YEARS	A D V **	15 YEARS OR OVER	SICK LEAVE
1	1-1-56	1-14-56	104	4	160	6	208	8	4
2	1-15	1-28	100	8	154	12	200	16	8
3	1-29	2-11	96	12	148	18	192	24	12
4	2-12	2-25	92	16	142	24	184	32	16
5	2-26	3-10	88	20	136	30	176	40	20
6	3-11	3-24	84	24	130	36	168	48	24
7	3-25	4-7	80	28	124	42	160	56	28
8	4-8	4-21	76	32	118	48	152	64	32
9	4-22	5-5	72	36	112	54	144	72	36
10	5-6	5-19	68	40	106	60	136	80	40
11	5-20	6-2	64	44	100	66	128	88	44
12	6-3	6-16	60	48	94	72	120	96	48
13	6-17	6-30	56	52	88	78	112	104	52
14	7-1	7-14	52	56	82	84	104	112	56
15	7-15	7-28	48	60	76	90	96	120	60
16	7-29	8-11	44	64	70	96	88	128	64
17	8-12	8-25	40	68	64	102	80	136	68
18	8-26	9-8	36	72	58	108	72	144	72
19	9-9	9-22	32	76	52	114	64	152	76
20	9-23	10-6	28	80	46	120	56	160	80
21	10-7	10-20	24	84	40	126	48	168	84
22	10-21	11-3	20	88	34	132	40	176	88
23	11-4	11-17	16	92	28	138	32	184	92
24	11-18	12-1	12	96	22	144	24	192	96
25	12-2	12-15	8	100	16	150	16	200	100
26	12-16	12-29-56	4	104	10	x* 160	8	208	104
27	12-30	1-12-57	0	108	0	166	0	216	108

Annual and Sick Leave accrues while in a pay status by pay periods only - no leave earned for any partial pay period.

* Leave year ends on 1-12-57. (Annual leave accumulation to be determined at close of this pay period).

x* 10 hours earned last complete pay period for employees in this category each year.

** In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

LEAVE ACCRUAL CHART FOR 1957

NO.	PERIOD FROM	PERIOD TO	ANNUAL LEAVE A D V	LESS THAN 3 YEARS	A D V	3 YRS. BUT LESS THAN 15 YEARS	A D V	15 YEARS OR OVER	SICK LEAVE
1	1-13-57	1-26-57	** 100	4	** 154	6	** 200	8	4
2	1-27	2-9	96	8	148	12	192	16	8
3	2-10	2-23	92	12	142	18	184	24	12
4	2-24	3-9	88	16	136	24	176	32	16
5	3-10	3-23	84	20	130	30	168	40	20
6	3-24	4-6	80	24	124	36	160	48	24
7	4-7	4-20	76	28	118	42	152	56	28
8	4-21	5-4	72	32	112	48	144	64	32
9	5-5	5-18	68	36	106	54	136	72	36
10	5-19	6-1	64	40	100	60	128	80	40
11	6-2	6-15	60	44	94	66	120	88	44
12	6-16	6-29	56	48	88	72	112	96	48
13	6-30	7-13	52	52	82	78	104	104	52
14	7-14	7-27	48	56	76	84	96	112	56
15	7-28	8-10	44	60	70	90	88	120	60
16	8-11	8-24	40	64	64	96	80	128	64
17	8-25	9-7	36	68	58	102	72	136	68
18	9-8	9-21	32	72	52	108	64	144	72
19	9-22	10-5	28	76	46	114	56	152	76
20	10-6	10-19	24	80	40	120	48	160	80
21	10-20	11-2	20	84	34	126	40	168	84
22	11-3	11-16	16	88	28	132	32	176	88
23	11-17	11-30	12	92	22	138	24	184	92
24	12-1	12-14	8	96	16	144	16	192	96
25	12-15	12-28	4	100	10	x* 154	8	200	100
26	* 12-29	1-11-58	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only - no leave earned for any partial pay period.

* Leave year ends on 1-11-58. (Annual leave accumulation to be determined at close of this pay period).

x* 10 hours earned last complete pay period in the calendar year for employees in this category.

** In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

Leave Accrual Chart for 1958

No.	Period		Annual leave						Sick leave
	From—	To—	Advanced [1]	Less than 3 years	Advanced [1]	3 years but less than 15 years	Advanced [1]	15 years or over	
1	1-12-58	1-25-58	100	4	154	6	200	8	4
2	1-26-58	2-8-58	96	8	148	12	192	16	8
3	2-9-58	2-22-58	92	12	142	18	184	24	12
4	2-23-58	3-8-58	88	16	136	24	176	32	16
5	3-9-58	3-22-58	84	20	130	30	168	40	20
6	3-23-58	4-5-58	80	24	124	36	160	48	24
7	4-6-58	4-19-58	76	28	118	42	152	56	28
8	4-20-58	5-3-58	72	32	112	48	144	64	32
9	5-4-58	5-17-58	68	36	106	54	136	72	36
10	5-18-58	5-31-58	64	40	100	60	128	80	40
11	6-1-58	6-14-58	60	44	94	66	120	88	44
12	6-15-58	6-28-58	56	48	88	72	112	96	48
13	6-29-58	7-12-58	52	52	82	78	104	104	52
14	7-13-58	7-26-58	48	56	76	84	96	112	56
15	7-27-58	8-9-58	44	60	70	90	88	120	60
16	8-10-58	8-23-58	40	64	64	96	80	128	64
17	8-24-58	9-6-58	36	68	58	102	72	136	68
18	9-7-58	9-20-58	32	72	52	108	64	144	72
19	9-21-58	10-4-58	28	76	46	114	56	152	76
20	10-5-58	10-18-58	24	80	40	120	48	160	80
21	10-19-58	11-1-58	20	84	34	126	40	168	84
22	11-2-58	11-15-58	16	88	28	132	32	176	88
23	11-16-58	11-29-58	12	92	22	138	24	184	92
24	11-30-58	12-13-58	8	96	16	144	16	192	96
25	12-14-58	12-27-58	4	100	10	[2] 154	8	200	100
26	[3] 12-28-58	1-10-59	0	104	0	160	0	208	104

Annual and sick leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period.

[1] In the event the annual leave balance reported on S. F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

[2] 10 hours earned least complete pay period in the calendar year for employees in this category.

[3] Leave year ends on 1-10-59. (Annual leave accumulation to be determined at close of this pay period.)

Leave Accrual Chart for 1959

No.	Period		Annual leave						Sick leave
	From—	To—	Advanced [1]	Less than 3 years	Advanced [1]	3 years but less than 15 years	Advanced [1]	15 years or over	
1	1-11-59	1-24-59	100	4	154	6	200	8	4
2	1-25-59	2-7-59	96	8	148	12	192	16	8
3	2-8-59	2-21-59	92	12	142	18	184	24	12
4	2-22-59	3-7-59	88	16	136	24	176	32	16
5	3-8-59	3-21-59	84	20	130	30	168	40	20
6	3-22-59	4-4-59	80	24	124	36	160	48	24
7	4-5-59	4-18-59	76	28	118	42	152	56	28
8	4-19-59	5-2-59	72	32	112	48	144	64	32
9	5-3-59	5-16-59	68	36	106	54	136	72	36
10	5-17-59	5-30-59	64	40	100	60	128	80	40
11	5-31-59	6-13-59	60	44	94	66	120	88	44
12	6-14-59	6-27-59	56	48	88	72	112	96	48
13	6-28-59	7-11-59	52	52	82	78	104	104	52
14	7-12-59	7-25-59	48	56	76	84	96	112	56
15	7-26-59	8-8-59	44	60	70	90	88	120	60
16	8-9-59	8-22-59	40	64	64	96	80	128	64
17	8-23-59	9-5-59	36	68	58	102	72	136	68
18	9-6-59	9-19-59	32	72	52	108	64	144	72
19	9-20-59	10-3-59	28	76	46	114	56	152	76
20	10-4-59	10-17-59	24	80	40	120	48	160	80
21	10-18-59	10-31-59	20	84	34	126	40	168	84
22	11-1-59	11-14-59	16	88	28	132	32	176	88
23	11-15-59	11-28-59	12	92	22	138	24	184	92
24	11-29-59	12-12-59	8	96	16	144	16	192	96
25	12-13-59	12-26-59	4	100	10	[2] 154	8	200	100
26	[3] 12-27-59	1-9-60	0	104	0	160	0	208	104

Annual and sick leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period.

[1] In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

[2] 10 hours earned last complete pay period in the calendar year for employees in this category.

[3] Leave year ends on 1-9-60. (Annual leave accumulation to be determined at close of this pay period.)

FORM 3 (Year 1960)

LEAVE ACCRUAL CHART FOR 1960

	PERIOD		ANNUAL LEAVE						
NO.	FROM	TO	*** A D V	LESS THAN 3 YEARS	*** A D V	3 YRS. BUT LESS THAN 15 YEARS	*** A D V	15 YEARS OR OVER	SICK LEAVE
1	1-10-60	1-23-60	100	4	154	6	200	8	4
2	1-24	2-6	96	8	148	12	192	16	8
3	2-7	2-20	92	12	142	18	184	24	12
4	2-21	3-5	88	16	136	24	176	32	16
5	3-6	3-19	84	20	130	30	168	40	20
6	3-20	4-2	80	24	124	36	160	48	24
7	4-3	4-16	76	28	118	42	152	56	28
8	4-17	4-30	72	32	112	48	144	64	32
9	5-1	5-14	68	36	106	54	136	72	36
10	5-15	5-28	64	40	100	60	128	80	40
11	5-29	6-11	60	44	94	66	120	88	44
12	6-12	6-25	56	48	88	72	112	96	48
13	6-26	7-9	52	52	82	78	104	104	52
14	7-10	7-23	48	56	76	84	96	112	56
15	7-24	8-6	44	60	70	90	88	120	60
16	8-7	8-20	40	64	64	96	80	128	64
17	8-21	9-3	36	68	58	102	72	136	68
18	9-4	9-17	32	72	52	108	64	144	72
19	9-18	10-1	28	76	46	114	56	152	76
20	10-2	10-15	24	80	40	120	48	160	80
21	10-16	10-29	20	84	34	126	40	168	84
22	10-30	11-12	16	88	28	132	32	176	88
23	11-13	11-26	12	92	22	138	24	184	92
24	11-27	12-10	8	96	16	144	16	192	96
25	12-11	12-24	4	100	10	** 154	8	200	100
26	* 12-25	1-7-61	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period

*Leave year ends on 1-7-61. (Annual leave accumulation to be determined at close of this pay period.)

**10 hours earned last complete pay period in the calendar year for employees in this category.

***In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

FORM 3 (Year 1962)

LEAVE ACCRUAL CHART FOR 1962

	PERIOD		ANNUAL LEAVE						
NO.	FROM	TO	*** A D V	LESS THAN 3 YEARS	*** A D V	3 YRS. BUT LESS THAN 15 YEARS	*** A D V	15 YEARS OR OVER	SICK LEAVE
1	1-7-62	1-20-62	100	4	154	6	200	8	4
2	1-21	2-3	96	8	148	12	192	16	8
3	2-4	2-17	92	12	142	18	184	24	12
4	2-18	3-3	88	16	136	24	176	32	16
5	3-4	3-17	84	20	130	30	168	40	20
6	3-18	3-31	80	24	124	36	160	48	24
7	4-1	4-14	76	28	118	42	152	56	28
8	4-15	4-28	72	32	112	48	144	64	32
9	4-29	5-12	68	36	106	54	136	72	36
10	5-13	5-26	64	40	100	60	128	80	40
11	5-27	6-9	60	44	94	66	120	88	44
12	6-10	6-23	56	48	88	72	112	96	48
13	6-24	7-7	52	52	82	78	104	104	52
14	7-8	7-21	48	56	76	84	96	112	56
15	7-22	8-4	44	60	70	90	88	120	60
16	8-5	8-18	40	64	64	96	80	128	64
17	8-19	9-1	36	68	58	102	72	136	68
18	9-2	9-15	32	72	52	108	64	144	72
19	9-16	9-29	28	76	46	114	56	152	76
20	9-30	10-13	24	80	40	120	48	160	80
21	10-14	10-27	20	84	34	126	40	168	84
22	10-28	11-10	16	88	28	132	32	176	88
23	11-11	11-24	12	92	22	138	24	184	92
24	11-25	12-8	8	96	16	144	16	192	96
25	12-9	12-22	4	100	10	** 154	8	200	100
26	* 12-23	1-5-63	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only - no leave earned for any partial pay period.

* Leave year ends on 1-5-63. (Annual leave accumulation to be determined at close of this pay period.)

** 10 hours earned last complete pay period in the calendar year for employees in this category.

*** In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

Leave Accrual Chart for 1963

Period			Annual Leave						Sick leave
No.	From	To	ADV ***	Less than 3 years	ADV ***	3 years but less than 15 years	ADV ***	15 years or over	
1	1-6-63	1-19-63	100	4	154	6	200	8	4
2	1-20	2-2	96	8	148	12	192	16	8
3	2-3	2-16	92	12	142	18	184	24	12
4	2-17	3-2	88	16	136	24	176	32	16
5	3-3	3-16	84	20	130	30	168	40	20
6	3-17	3-30	80	24	124	36	160	48	24
7	3-31	4-13	76	28	118	42	152	56	28
8	4-14	4-27	72	32	112	48	144	64	32
9	4-28	5-11	68	36	106	54	136	72	36
10	5-12	5-25	64	40	100	60	128	80	40
11	5-26	6-8	60	44	94	66	120	88	44
12	6-9	6-22	56	48	88	72	112	96	48
13	6-23	7-6	52	52	82	78	104	104	52
14	7-7	7-20	48	56	76	84	96	112	56
15	7-21	8-3	44	60	70	90	88	120	60
16	8-4	8-17	40	64	64	96	80	128	64
17	8-18	8-31	36	68	58	102	72	136	68
18	9-1	9-14	32	72	52	108	64	144	72
19	9-15	9-28	28	76	46	114	56	152	76
20	9-29	10-12	24	80	40	120	48	160	80
21	10-13	10-26	20	84	34	126	40	168	84
22	10-27	11-9	16	88	28	132	32	176	88
23	11-10	11-23	12	92	22	138	24	184	92
24	11-24	12-7	8	96	16	144	16	192	96
25	12-8	12-21	4	100	10	**154	8	200	100
26	*12-22	1-4-64	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period.

*Leave year ends on 1-4-64. (Annual leave accumulation to be determined at close of this pay period.)

**10 hours earned last complete pay period in the calendar year for employees in this category.

***In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

FORM 3 (Year 1964)

Leave Accrual Chart for 1964

Period			Annual leave						Sick leave
No.	From	To	ADV ***	Less than 3 years	ADV ***	3 years but less than 15 years	ADV ***	15 years or over	
1	1-5-64	1-18-64	100	4	154	6	200	8	4
2	1-19	2-1	96	8	148	12	192	16	8
3	2-2	2-15	92	12	142	18	184	24	12
4	2-16	2-29	88	16	136	24	176	32	16
5	3-1	3-14	84	20	130	30	168	40	20
6	3-15	3-28	80	24	124	36	160	48	24
7	3-29	4-11	76	28	118	42	152	56	28
8	4-12	4-25	72	32	112	48	144	64	32
9	4-26	5-9	68	36	106	54	136	72	36
10	5-10	5-23	64	40	100	60	128	80	40
11	5-24	6-6	60	44	94	66	120	88	44
12	6-7	6-20	56	48	88	72	112	96	48
13	6-21	7-4	52	52	82	78	104	104	52
14	7-5	7-18	48	56	76	84	96	112	56
15	7-19	8-1	44	60	70	90	88	120	60
16	8-2	8-15	40	64	64	96	80	128	64
17	8-16	8-29	36	68	58	102	72	136	68
18	8-30	9-12	32	72	52	108	64	144	72
19	9-13	9-26	28	76	46	114	56	152	76
20	9-27	10-10	24	80	40	120	48	160	80
21	10-11	10-24	20	84	34	126	40	168	84
22	10-25	11-7	16	88	28	132	32	176	88
23	11-8	11-21	12	92	22	138	24	184	92
24	11-22	12-5	8	96	16	144	16	192	96
25	12-6	12-19	4	100	10	**154	8	200	100
26	*12-20	1-1-65	0	104	0	160	0	208	104

Annual and Sick Leave accrues while in a pay status by pay periods only—no leave earned for any partial pay period.

*Leave year ends on 1-1-65. (Annual leave accumulation to be determined at close of this pay period.)

**10 hours earned last complete pay period in the calendar year for employees in this category.

***In the event the annual leave balance reported on S.F. 1130 opposite "Balance at the close of this period" is red, such red balance must not exceed the figure shown in this column for the corresponding period as the excess must be charged to leave without pay.

NAME Stone, Alice F.

Reporting Unit U. S. Attorney's Office

Agency Justice

Pay Period No. 2 - 1/2/55 - 1/15/55

	SICK	ANNUAL	HOURS OF DUTY OF N/D OR OTHER THAN REGULAR
Leave balances brought forward from prior period	427	304	
Leave accrued during this reporting period	4	8	
Aggregate of leave available during this period	431	312	

TIME AND ATTENDANCE REPORT
Standard Form No. 1130
(General Regulations No. 102—Rev.)
Form prescribed by Comp. Gen., U. S.
May 17, 1946

REMARKS

Leave year begins 1/2/55

Ceiling 304 Hrs.

TOTAL HOURS IN	TOTAL HOURS OUT	DATE	TIME WORKED: REGULAR	N/D	O/T		COMPENSATORY	TIME ABSENT: COMPENSATORY	AWOL	LWOP	SICK	ANNUAL	OTHER	INITIALS*
		Sun.												
		Mon.												
		Tue.												
		Wed.												
		Thu.												
		Fri.												
		Sat.												
FIRST WEEK TOTAL											x x x	x x x		
		Sun.												
		Mon.												
		Tue.												
		Wed.												
		Thu.												
		Fri.												
		Sat.												
SECOND WEEK TOTAL											x x x	x x x		
PAY PERIOD TOTAL														

COMPENSATORY TIME	
Brought forward	
Worked this pay period	
Total for this pay period	
Used this pay period	
Paid this pay period	
Balance at end of this pay period	

		SICK	ANNUAL	Tel.
Balances at close of this period	x x x			
W. O. P. total for calendar year to end of prior period				
W. O. P. total for calendar year to end of this period				

*Certification for SICK LEAVE.
I certify that this absence was due to illness which incapacitated me for duty.

16—46691-3 GPO O-467196

Certified correct

(Supervisor or timekeeper)

NAME Stone, Alice F.
Reporting Unit U. S. Attorney's Office
Agency Justice
Pay Period No. 1 - 12/19/54 - 1/1/55

	SICK	ANNUAL	HOURS OF DUTY IF N/D OR OTHER THAN REGULAR
Leave balances brought forward from prior period	423	380	
Leave accrued during this reporting period	4	8	
Aggregate of leave available during this period	427	388	

TIME AND ATTENDANCE REPORT
Standard Form No. 1130
(General Regulations No. 102—Rev.)
Form prescribed by Comp. Gen., U. S.
May 17, 1946

REMARKS

* 336 Bal. 1/1/55
304 Ceiling
32 Hrs. forfeited

TOTAL HOURS IN	TOTAL HOURS OUT	DATE	TIME WORKED REGULAR	N/D	O/T		COMPENSATORY	TIME ABSENT COMPENSATORY	AWOL	LWOP	SICK	ANNUAL	OTHER	INITIALS*
		Sun.												
		Mon.	✓											
		Tue.	✓											
		Wed.										8		
		Thu.										8		
		Fri.	H											
		Sat.												
FIRST WEEK TOTAL			16								x x x	x x x		
		Sun.												
		Mon.										8		
		Tue.										8		
		Wed.										8		
		Thu.										8		
		Fri.										4		S.F.71
		Sat.												
SECOND WEEK TOTAL			—								x x x	x x x		
PAY PERIOD TOTAL			16									52		

COMPENSATORY TIME
Brought forward
Worked this pay period
Total for this pay period
Used this pay period
Paid this pay period
Balance at end of this pay period

		SICK	ANNUAL
Balances at close of this period	x x x	427	336* Tel.
W. O. P. total for calendar year to end of prior period			
W. O. P. total for calendar year to end of this period			

*Certification for Sick Leave.
I certify that this absence was due to illness which incapacitated me for duty.

16—46601-2 ☆GPO 0-907175

Certified correct
M. Palmer
(Supervisor or timekeeper)

Name: Brown, John R. Jr.

Reporting Unit: U. S. Attorney's Office

Agency: Justice

Pay Period No.: 24 - 11/7/54 - 11/20/54

Leave	Sick	Annual
Leave balances brought forward from prior period	102	156
Leave accrued during this reporting period	4	8
Aggregate of leave available during this period	106	164

Hours of duty if N/D or other than regular:

TIME AND ATTENDANCE REPORT
Standard Form No. 1130
(General Regulations No. 103—Rev.)
Form prescribed by Comp. Gen., U.S. May 17, 1946

REMARKS

3 Hrs. compensatory overtime ordered by U.S. Atty., H. Light, 11/12

Total Hours In	Total Hours Out	Date	Time Worked: Regular	N/D	O/T		Compensatory	Time Absent: Compensatory	[illegible]	LWOP	Sick	Annual	Other	Initials*
		Sun.												
		Mon.	4								4			JRB
		Tue.	✓											
		Wed.	✓											
		Thu.	H											
		Fri.	✓				3							
		Sat.												
First week total			28				3				x x x	x x x		
		Sun.												
		Mon.	✓											
		Tue.	6					2						JRB
		Wed.	✓											
		Thu.										8		JRB
		Fri.	✓											
		Sat.												
Second week total			30								x x x	x x x		
Pay period total			58				3	2			4	8		

Compensatory Time	
Brought forward	10
Worked this pay period	3
Total for this pay period	13
Used this pay period	2
Paid this pay period	
Balance at end of this pay period	11

		Sick	Annual	
Balances at close of this period	x x x	102	156	Tel.
W. O. P. total for calendar year to end of prior period				
W. O. P. total for calendar year to end of this period				

*Certification for Sick Leave.
I certify that his absence was due to illness which incapacitated me for duty.

Certified correct
M. Palmer
(Supervisor or timekeeper)

FORM 5

Form No. USM-101
(Ed. 4-3-59)

REPORT OF SEIZED PROPERTY

For the quarter ended ____________

__________ District ____________ ____________
(Date)

(1) Court Case No.	(2) Title of Case and Type of Violation	(3) Description of Property	(4) Date Seized	(5) Monthly Storage Expense	(6) Accrued Unpaid Expense	(7) Reasons Why Case Not Terminated, etc.	(8) Probable Disposition Date

FORM 8 (face)

NAME *(Print or type - Last, First, Middle Initial)*

IDENTIFICATION NO.

ORGANIZATIONAL UNIT

FROM *(Mo., Day, Hr.)* a.m. p.m.

NO. OF HOURS

TYPE OF LEAVE

☐ ANNUAL ☐ SICK ☐ WITHOUT PAY ☐ COMPEN-SATORY ☐ OTHER

TO *(Mo., Day, Hr.)* a.m. p.m.

I understand that any annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP.

NOTE TO EMPLOYEE - *(If you are applying for sick leave check appropriate box)*

DURING THIS ABSENCE I WAS

☐ INCAPACITATED FOR DUTY BY SICKNESS OR INJURY

☐ INCAPACITATED FOR DUTY BY PREGNANCY AND CONFINEMENT

☐ UNDERGOING MEDICAL, DENTAL OR OPTICAL EXAMINATION OR TREATMENT

☐ REQUIRED TO CARE FOR A MEMBER OF MY FAMILY WITH CONTAGIOUS DISEASE

NAME AND RELATIONSHIP OF FAMILY MEMBER AND NAME OF DISEASE

☐ REQUIRED TO BE ABSENT BECAUSE OF EXPOSURE TO CONTAGIOUS DISEASE

NAME OF DISEASE AND CIRCUMSTANCES OF EXPOSURE

REMARKS

SIGNATURE OF EMPLOYEE

DATE

STANDARD FORM 71
REVISED MARCH 1961

71-105

APPLICATION FOR LEAVE

U.S. CIVIL SERVICE COMMISSION
CHAPTER L-1, FPM

CERTIFICATE OF PHYSICIAN OR PRACTITIONER

The employee named was under my professional care during the period stated below. From the medical standpoint, his condition during this period was such that I considered it inadvisable for him to report to work.

NAME OF EMPLOYEE		POSITION OCCUPIED
PERIOD UNDER PROFESSIONAL CARE	FROM *(Mo., day, year)*	THROUGH *(Mo., day, year)*
REMARKS		
SIGNATURE OF PHYSICIAN OR PRACTITIONER		DATE

OFFICIAL ACTION ON APPLICATION

☐ APPROVED ☐ DISAPPROVED *(If disapproved, give reason)*	SIGNATURE AND DATE

* U.S. GOVERNMENT PRINTING OFFICE . 1961 O—572735

FORM 9 (face)

1. LAST NAME: Doe | FIRST NAME: Joe | INITIAL(S):

2. APPOINTMENT DATA — Entered on duty: June 26, 1933 | F/T: X | P/T:

3. TOTAL SERVICE FOR LEAVE (as of date of separation) — Years: 19 | Months: 8 | Days: 2 | ☒ More than 15 years

4. DATE AND NATURE OF SEPARATION: Resignation effective at close of business 2/28/53

SUMMARY OF LEAVE (HOURS)

ITEM			ANNUAL	SICK
5. Balance brought forward from prior year			674	816
6. Current year accrual through			40	20
7. TOTAL			714	836
	ANNUAL	SICK		
8. Reduction in credits, if any (current year)				
9. Total leave taken	13	51		
	TOTALS →		13	51
10. Balance transferred or included in lump sum			701	785

11. Total hours paid in lump sum: 701 hours

12. Salary rate(s): $9160.00

13. Lump-sum leave period: From 3-1-53 (Date) Hours 8, To 7-1-53 (Date) Hours 5

ABSENCE WITHOUT PAY	HOURS
14. During calendar year in which separated	0
15. Since waiting period for step-increase which began on	XXXXX
a. LWOP and/or furlough	0
b. AWOL and/or suspension	0
	DAYS
16. Military leave granted during current calendar year	0

17. Remarks:

18. Certified correct by: Feb. 28, 1953 (Date) — Signature — United States Attorney (Title)

18a. Address and phone number for purposes of inquiries: United States Attorney, Phoenix, Arizona (telephone Alpine 3-8201)

Standard Form No. 1150-Rev. Form prescribed by Comp. Gen., U.S. January 5, 1950 Gen. Reg. No. 111, Supp. No. 2

RECORD OF LEAVE DATA TRANSFERRED

INSTRUCTIONS FOR THE PREPARATION OF STANDARD FORM NO. 1150-REV., RECORD OF LEAVE DATA TRANSFERRED

1. Enter the name and middle initials(s) of employee covered by the form.
2. Indicate employee's status for leave purposes by filling in date of entrance on duty at the releasing organization, and insert X for F/T (Full Time or P/T (Part Time).
3. Show employee's total creditable service for leave purposes, as of date of separation, in years, months, and days.
4. Show same information that appears on Standard Form No. 50, Notification of Personnel Action, effecting separation.
5. Enter balances of annual and sick leave brought forward from close of previous year.

(OVER)

FORM 9 (back)

6. Enter final date through which leave has been credited, and enter the amount of annual and sick leave earned and credited since the beginning of the current year.

7. Enter the sum of the prior balances and current accruals.

8. Enter as an item to be subtracted, the reduction in credits caused by absences in non-pay status.

9. Enter as an item for subtraction, the total number of hours of annual and sick leave taken during the current year through date of separation as shown in Item 4.

10. Enter the figures derived by subtracting the total reduction in credits and leave taken from the total figures in Item 7.

11. Enter number of hours of annual leave (including applicable holiday time) paid in lump-sum at time of separation.

12. Enter salary rate at which lump-sum payment was computed. If more than one salary rate was involved, state the number of hours computed at each rate.

13. Enter the inclusive calendar dates and number of hours on such dates included in the lump-sum leave period.

14. Enter the number of hours absence in a non-pay status during calendar year in which separated.

15. Enter the beginning date of the waiting period for step increase, and

    a. Total number of hours of leave without pay and/or furlough since waiting period began, and

    b. Total number of hours of absence without leave and/or suspension since waiting period began.

16. Enter number of days of military leave for training purposes, as distinguished from active duty periods, granted from beginning of current calendar year.

17. Enter pertinent information not specifically required elsewhere on the form, such as overseas or territorial differential, etc.

18. The person having responsibility for accuracy of leave records will sign this form, indicating his title and the date.

18a. Enter address and phone number to which inquiries regarding this record should be directed.

FORM 10 (front)

FOR INSTRUCTIONS SEE INFORMATION ON BACK OF SHEET

I Suggest:

(Please Print)

NAME: MR. / MRS. / MISS		
POSITION	GRADE SALARY	SIGNATURE DATE
DIVISION AND ROOM NO.	TEL. EXTENSION	SUGGESTION NO. DATE RECEIVED (For use of Awards Committee)

FORM NO. DJ-17
(ED. 6-8-55)

FORM 10 (back)

WE WANT SUGGESTIONS

Any proposal that can improve the Department's work, or which will result in improvement or economy in operations of the Department, improved working conditions or morale, or better service to the public, is welcome.

HOW TO SUBMIT YOUR SUGGESTION

1. Put only one suggestion on this form—if you need more space use plain paper. Submit in triplicate.
2. If you want assistance in preparing your suggestion, see your supervisor or contact the Personnel Office of the Department.
3. Explain your suggestion clearly and completely, giving full details. SHOW ESTIMATE OF SAVINGS WHENEVER POSSIBLE.
4. Suggestions may be submitted through your supervisor, dropped in a suggestion box, or sent directly to the Departmental Incentive Awards Committee.
5. If your suggestion is rejected, do not let it discourage you. Keep trying.

FORM 12 (face of original)

WARNING—Do not fill out this form until you have read the instructions.	**DESIGNATION OF BENEFICIARY** CIVIL SERVICE RETIREMENT SYSTEM	STANDARD FORM NO. [illegible] FORM PRESCRIBED BY COMPTROLLER GENERAL, U. S. JUNE [illegible], [illegible] (GEN. REG. NO. 105, SUPP. NO. 2)

A. INFORMATION CONCERNING THE DESIGNATOR

1. NAME- *(Last)* *(First)* *(Middle)*	2. DATE OF BIRTH *(Month)* *(Day)* *(Year)*	3. DATE OF THIS DESIGNATION *(Month)* *(Day)* *(Year)*

4. DEPARTMENT OR AGENCY IN WHICH PRESENTLY OR LAST EMPLOYED, INCLUDING BUREAU OR DIVISION	5. CLAIM NUMBER IF RETIRED CSA—

I, the employee or former employee identified above, canceling any and all previous designations of beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Civil Service Retirement Act after my death. I understand that this designation of beneficiary will not affect the rights of any survivors who may qualify for annuity benefits after my death, and that this designation will remain in full force and effect unless or until canceled by me in writing.

B. INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary or beneficiaries who may die before a lump-sum benefit becomes payable shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive when the lump-sum benefit becomes payable, this designation shall be void.

____
(SIGNATURE OF DESIGNATOR—DO NOT PRINT)

C. WITNESSES

WE, THE UNDERSIGNED, CERTIFY THAT THIS INSTRUMENT WAS SIGNED IN OUR PRESENCE.

(SIGNATURE OF WITNESS—DO NOT PRINT)	(NUMBER AND STREET)	(CITY, ZONE NUMBER, AND STATE)
(SIGNATURE OF WITNESS—DO NOT PRINT)	(NUMBER AND STREET)	(CITY, ZONE NUMBER, AND STATE)

PRINT OR TYPE YOUR NAME AND ADDRESS TO INSURE RETURN OF COPY	*(Reserved for Receiving Stamp of U. S. Civil Service Commission)*

MAIL BOTH COPIES TO THE UNITED STATES CIVIL SERVICE COMMISSION, WASHINGTON 25, D. C. [illegible]

FORM 12 (back of original)

IMPORTANT.—The Filing of This Form Completely Cancels Any Designation You May Have Previously Filed. Be Sure To Name In This Form All Persons You Wish To Designate As Beneficiaries.

EXAMPLES OF DESIGNATIONS

HOW TO DESIGNATE ONE BENEFICIARY

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY
SARAH M. JONES	22 Elm Street, Lima, Ohio	Sister	All

Do not write name as S. M. Jones or as Mrs. George L. Jones.

HOW TO DESIGNATE MORE THAN ONE BENEFICIARY

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY
MARY A. SMITH	4902 Oak Street, Jason, North Dakota	Aunt	One-half
ANNA D. BROWN	50 Duke Street, Jason, North Dakota	Cousin	One-fourth
HENRY G. BROWN	50 Duke Street, Jason, North Dakota	Cousin	One-fourth

Be sure the shares to be paid to the beneficiaries add up to 100%.

HOW TO DESIGNATE A CONTINGENT BENEFICIARY

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY
CATHERINE J. ANDERSON, if living	91 Adams Place, Syracuse, New York	Niece	All
Otherwise to: JOHN L. JONES	69 Harris Avenue, Cleveland, Ohio	Nephew	All

HOW TO CANCEL A DESIGNATION OF BENEFICIARY

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY
Cancel Prior Designation			

You may want to cancel a beneficiary you have named if your circumstances change and you want the benefit payable to your wife or husband, children, or parents in that order.

U. S. GOVERNMENT PRINTING OFFICE 16—[illegible]

FORM 12 (face of duplicate)

WARNING—Do not fill out this form until you have read the instructions.

DESIGNATION OF BENEFICIARY

CIVIL SERVICE RETIREMENT SYSTEM

STANDARD FORM NO. [illegible]
FORM PRESCRIBED BY COMPTROLLER GENERAL, U. S.
JUNE [illegible], [illegible]
([illegible])

A. INFORMATION CONCERNING THE DESIGNATOR

1. NAME (*Last*) (*First*) (*Middle*)	2. DATE OF BIRTH (*Month*) (*Day*) (*Year*)	3. DATE OF THIS DESIGNATION (*Month*) (*Day*) (*Year*)

4. DEPARTMENT OR AGENCY IN WHICH PRESENTLY OR LAST EMPLOYED, INCLUDING BUREAU OR DIVISION	5. CLAIM NUMBER IF RETIRED
	CSA—

I, the employee or former employee identified above, canceling any and all previous designations of beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Civil Service Retirement Act after my death. I understand that this designation of beneficiary will not affect the rights of any survivors who may qualify for annuity benefits after my death, and that this designation will remain in full force and effect unless or until canceled by me in writing.

B. INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES

TYPE OR PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME OF EACH BENEFICIARY	TYPE OR PRINT ADDRESS OF EACH BENEFICIARY	RELATIONSHIP	SHARE TO BE PAID TO EACH BENEFICIARY

DUPLICATE

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary or beneficiaries who may die before a lump-sum benefit becomes payable shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive when the lump-sum benefit becomes payable, this designation shall be void.

____
(SIGNATURE OF DESIGNATOR—DO NOT PRINT)

C. WITNESSES

WE, THE UNDERSIGNED, CERTIFY THAT THIS INSTRUMENT WAS SIGNED IN OUR PRESENCE.

(SIGNATURE OF WITNESS—DO NOT PRINT)	(NUMBER AND STREET)	(CITY, ZONE NUMBER, AND STATE)
(SIGNATURE OF WITNESS—DO NOT PRINT)	(NUMBER AND STREET)	(CITY, ZONE NUMBER, AND STATE)

PRINT OR TYPE YOUR NAME AND ADDRESS TO INSURE RETURN OF COPY	(*Reserved for Receiving Stamp of U. S. Civil Service Commission*)

THIS DUPLICATE WILL BE RETURNED TO YOU

[illegible]

FORM 12 (back of duplicate)

WARNING—Do not fill out this form if you are satisfied to have any lump-sum benefit which may become payable after your death paid according to the order of precedence which follows.

RETIREMENT ACT ORDER OF PRECEDENCE

If there is no designated beneficiary living, any lump-sum benefit which becomes payable after the death of an employee or former employee will be payable to the first person or persons listed below who are alive on the date title to the payment arises.

1. To the widow or widower.
2. If neither of the above, to the child or children in equal shares, with the share of any deceased child distributed among the descendants of that child.
3. If none of the above, to the parents in equal shares or the entire amount to the surviving parent.
4. If none of the above, to the executor or administrator of the estate of the decedent.
5. If none of the above, to the next of kin under the laws of the State in which the decedent was domiciled.

It is not necessary for any employee or former employee to designate a beneficiary unless he wishes to name some person or persons not included above, or in a different order.

PURPOSE OF DESIGNATING A BENEFICIARY

A designation of beneficiary is for lump-sum benefit purposes only, and does not affect the right of any person who qualifies to receive *survivor annuity* benefits. Such benefits are payable either by operation of law or as a result of an election made by a retiring employee. Survivor annuity benefits are never based on this form.

INSTRUCTIONS

1. The examples printed on the back of the first page may be helpful to you.
2. Type or print all entries except signatures.
3. Fill out and mail both copies to the United States Civil Service Commission, Washington 25, D. C. The designation of a beneficiary must be received by the Civil Service Commission prior to the death of the employee or former employee to be valid.
4. Cancellation of a prior designation may be effected without the naming of a new beneficiary by making out a new Standard Form 2808 and inserting in the space provided for name of beneficiary, the words, "Cancel Prior Designation." All designations of beneficiary filed before September 1, 1950, have been canceled by law. It is not necessary to file a new form to cancel a designation made before that date.
5. This form is not intended as a will, and miscellaneous provisions, such as payment of just debts, payment on the monthly installment plan, etc., will not be recognized.
6. A designation free of erasures or alterations should be filed in order to avoid a possible contest after death.
7. The duplicate will be returned to you as evidence that the original has been received and filed. When you receive the duplicate, file it with your important papers. After your death the beneficiary, or someone acting for the beneficiary, should request the Civil Service Commission to furnish a blank on which to make application for any lump-sum benefit which may be payable.

REGULATIONS

1. The designation of beneficiary shall be in writing, signed and witnessed, and received in the Civil Service Commission prior to the death of the designator.
2. No change or cancellation of beneficiary in a last will or testament, or in any other document not witnessed and filed as required by these regulations shall have any force or effect.
3. A witness to a designation of beneficiary is ineligible to receive payment as a beneficiary.
4. Any person, firm, corporation, or legal entity may be named as beneficiary.
5. A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary, and this right cannot be waived or restricted.

U. S. GOVERNMENT PRINTING OFFICE

FORM 13

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)*	2. DATE OF THIS NOTICE *(Mo., day, yr.)*
3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*	4. DATE OF INJURY *(Mo., day, yr.)*
5. OCCUPATION	6. HOUR OF INJURY *(a.m. or p.m.)*

7. PLACE OR LOCATION WHERE INJURY OCCURRED

8. CAUSE OF INJURY *(Describe how and why injury occurred)*

9. NATURE OF INJURY *(Name part of body affected—(fractured left leg, bruised right thumb, etc.)*

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.

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 13. HOME ADDRESS OF INJURED EMPLOYEE

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

FORM 13 (back)

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

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*

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 : [illegible]

OFFICIAL SUPERIOR'S REPORT OF INJURY

[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 employment

1. Department ______ *(War, Navy, etc.)* 2. Bureau or office ______ *(Engineer, Navigation, etc.)*
3. Place of employment ______ *(Arsenal, navy yard, etc.)*, ______ *(City)*, ______ *(State)*
4. Reporting office ______ *(Location of reporting office or division headquarters)*
5. Name of superintendent or foreman in charge when injury occurred ______

The injured employee

6. Name of injured employee ______ *(Give first name in full)* 7. Age ______ 8. Sex ______ 9. Race ______
10. Home address ______ *(Street and number)*, ______ *(City or town)*, ______ *(State)*
11. Occupation and division ______ *(Give both, as laborer, hull division; helper, machine shop, etc.)* 12. Was employee doing his regular work? ______ If not, what work? ______
13. Total length of service with the Government as a civilian? ______
14. 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 ______ m. *(Hour, a. m. or p. m.)* 18. Regular day's work ends ______ m. *(Hour, a. m. or p. m.)*
19. Hours worked per day ______ 20. Days paid per week ______

The injury

21. Place where injury occurred ______ *(Give exact location, as name or number of building and division, etc.)*
22. Date of injury ______, 19___; day of week ______; hour of day ______ m. *(a. m. or p. m.)*
23. Date employee stopped work ______, 19___; day of week ______; hour of day ______ 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? ______ *(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 ______
28. State part of body injured and nature and extent of injury ______
29. Did injury cause loss of any member or part of member? ______ If so, describe exactly ______
30. Was employee injured while in performance of duty? ______ If not, or in doubt, give detailed statement ______
31. Was injury caused by:
    (a) Willful misconduct of the employee? ______ (b) Intention of employee to bring about injury or death 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)
32. Was written notice of injury given within 48 hours? ______ If not, did immediate superior have actual knowledge of injury? ______ *(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? ______ 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 ______
36. How soon after injury? ______
37. To what hospital sent? ______ Location ______
38. Name and address of physician now attending case ______

Signed this ______ day of ______, 19___ ______ *(Signature of reporting officer)*

at ______ ______ *(Title)*

C. A. 2
Revised May 24, 1950

(OVER)

332954 O - 55 (Faces Blank p. 158.2)

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)*

FORM 14 (front)

OFFICIAL SUPERIOR'S REPORT OF INJURY

(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 employment

1. Department ________ (War, Navy, etc.) 2. Bureau or office ________ (Engineer, Navigation, etc.)
3. Place of employment ________ (Arsenal, navy yard, etc.), ________ (City), ________ (State)
4. Reporting office ________ (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred ________

The injured employee

6. Name of injured employee ________ (Give first name in full) 7. Age ____ 8. Sex ____ 9. Citizenship ________
10. Home address ________ (Street and number), ________ (City or town), ________ (State)
11. Occupation and division ________ (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? ________ If not, what work? ________
13. Total length of service with the Government as a civilian? ________
14. 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 ________ (Hour, a. m. or p. m.) m. 18. Regular day's work ends ________ (Hour, a. m. or p. m.) m.
19. Hours worked per day ________ 20. Days paid per week ________

The injury

21. Place where injury occurred ________ (Give exact location, as name or number of building and division, etc.)
22. Date of injury ________, 19____; day of week ________; hour of day ________ (a. m. or p. m.) m.
23. Date employee stopped work ________, 19____; day of week ________; hour of day ________ (a. m. or p. m.) m.
24. Date employee's pay stopped ________, 19____; day of week ________; hour of day ________ (a. m. or p. m.) m.
25. Has employee returned to work? ________ (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 ________
28. State part of body injured and nature and extent of injury ________
29. Did injury cause loss of any member or part of member? ________ If so, describe exactly ________
30. Was employee injured while in performance of duty? ________ If not, or in doubt, give detailed statement ________
31. Was injury caused by:
    (a) Willful misconduct of the employee? ________ (b) Intention of employee to bring about injury or death 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)
32. Was written notice of injury given within 48 hours? ________ If not, did immediate superior have actual knowledge of injury? ________ (Answer to question 4, 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? ________ 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 ________
36. How soon after injury? ________
37. To what hospital sent? ________ Location ________
38. Name and address of physician now attending case ________

Signed this ____ day of ________, 19____ ________ (Signature of reporting officer)

at ________ ________ (Title)

C. A. 2
December 1961

(over)

FORM 14 (back)

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)

U. S. GOVERNMENT PRINTING OFFICE : 1961 O—[illegible]

FORM 18

Form No. USA-5
(Rev. 11-1-62)

DEPARTMENT OF JUSTICE
MONTHLY STATISTICAL REPORT OF UNITED STATES ATTORNEY

______________ DISTRICT OF ______________

Month of __________, 19__

FINANCIAL SUMMARY

	TOTAL AMOUNT DURING MONTH		
	Imposed or Obtained A.	Collected B.	Remitted, Suspended or Compromised C.
1. Fines			
2. Forfeitures			
3. Penalties			
4. Other Civil Judgments in favor U. S.			
5. Total			

NOTE: Costs, whenever imposed or collected as part of judgments in favor of the U. S. or as part of fine, etc. should be included in the figures shown above.

	Criminal A.	Civil B.
6. Collections during the month through U. S. Attorney without actual suit or prosecution		

7. (a) Number of bonds forfeited during month . . . . ________
(b) Amount of bonds forfeited during month . . . . ________

MAN-HOURS SUMMARY

8. Man-hours in District Court . . . . ________
9. " before Grand Jury . . . . ________
10. " in Appellate Court . . . . ________
11. " in pretrial hearings . . . . ________
12. " in State Courts . . . . ________
13. " in Bankruptcy Court . . . . ________
14. " in proceedings before Commissioners, Special Masters Hearing Examiners, etc. . . . . ________

______________________________ (Signed) ______________________________

FORM 19

Form No. DJ-108
(Rev. 1-23-57)

REPORT OF PROCEEDINGS BEFORE UNITED STATES COMMISSIONER

To: UNITED STATES ATTORNEY

....

At .... on .... 19...

Proceedings in United States *vs.* ....

Description: Age .... Sex .... Race .... Born: Native ☐ Foreign ☐

Address ....

Name of complainant and title (if any) ....

.... Date of complaint ....

Offense charged .... Date of offense ....

Where committed .... Date of warrant ....

Date of hearing .... Examination waived ....

Bail fixed at $.................... { Released ....
{ Committed to ....

Discharged (date) ....

Name and address of surety ....

....

Names and residences of witnesses ....

....

....

....

....

Remarks ....

....

....

....

U. S. GOVERNMENT PRINTING OFFICE : 1957— O-415440

....
United States Commissioner.

FORM 20 (Face)

BILL OF COSTS

Form A. O. 133 Rev. 1-1-52

United States District Court
for the ....
Civil Action File No. ......
vs.

Judgment having been entered in the above-entitled action on the ...... day of ...., 19...., against .... the clerk is requested to tax the following as costs:

Bill of costs

Fees of the clerk	$________
Fees of the marshal......................................	________
Fees of the court reporter for all or any part of the transcript necessarily obtained for use in the case..................	________
Fees and disbursements for printing..........................	________
Fees for witnesses (itemized on reverse side)................	________
Fees for exemplification and copies of papers necessarily obtained for use in case..................................	________
Docket fees under 28 U. S. C. 1923..........................	________
Costs incident to taking of depositions.....................	________
Costs as shown on Mandate of Court of Appeals...............	________
Other Costs (Please itemize)................................	________
	________
	________
	________
	________
Total..	________

STATE OF ....,
County of ...., *ss:*

I, ...do hereby swear that the foregoing costs are correct and were necessarily incurred in this action and that the services for which fees have been charged were actually and necessarily performed. A copy hereof was this day mailed to .... with postage fully prepaid thereon.

Please take notice that I will appear before the Clerk to tax said costs on the ...... day of ...., 19.... at ....

....
Attorney for ....

Subscribed and sworn to before me this ...... day of .... A. D. 19.... at ....

....
Notary Public

Costs are hereby taxed in the amount of $.......... this ...... day of ...., 19...., and that amount included in the judgment.

....
Clerk

By ....
Deputy Clerk

***Note.*—SEE REVERSE SIDE FOR AUTHORITIES ON TAXING COSTS.**

Sept. 1, 1954

FORM 20 (Back)

Witness fees (computation, cf. 28 U. S. C. 1821 for statutory fees)

Name and residence	Attendance		Subsistence		Mileage		Total cost each witness
	Days	Total cost	Days	Total cost	Miles	Total cost	
					Total		

NOTICE

Section 1924, Title 28, U. S. Code (effective September 1, 1948) provides:

"Sec. 1924. Verification of bill of costs.

"Before any bill of costs is taxed, the party claiming any item of cost or disbursement shall attach thereto an affidavit, made by himself or by his duly authorized attorney or agent having knowledge of the facts, that such item is correct and has been necessarily incurred in the case and that the services for which fees have been charged were actually and necessarily performed."

See also Section 1920 of Title 28 which reads in part as follows:

"A bill of costs shall be filed in the case and, upon allowance, included in the judgment or decree."

The Federal Rules of Civil Procedure contain the following provisions:

Rule 54 (d)

"Except when express provision therefor is made either in a statute of the United States or in these rules, costs shall be allowed as of course to the prevailing party unless the court otherwise directs; but cost against the United States, its officers, and agencies shall be imposed only to the extent permitted by law. Costs may be taxed by the clerk on one day's notice. On motion served within 5 days thereafter, the action of the clerk may be reviewed by the court."

Rule 6 (e)

"Whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon him and the notice or paper is served upon him by mail, 3 days shall be added to the prescribed period."

Rule 58 (in Part)

"The entry of the judgment shall not be delayed for the taxing of costs."

Sept. 1, 1954

Form No. USA-200
(Rev. 3-3-58)
Form approved by
Comp. Gen., U. S.

Receipt No. 29993

DEPARTMENT OF JUSTICE

Office of United States Attorney

__________ District of __________

(CHECKS ACCEPTED SUBJECT TO COLLECTION)

Claim Against				U. S. Attorney's No.
Amount Received ($)				From
Agency & File No.				
Type Claim	Amt. of Claim	DJ File No.	( ) Pre-judgment ( ) Judgment ( ) Compromise	( ) Paid in full ( ) Partial Pay No.
Date Payment Received		By		for UNITED STATES ATTORNEY

Original — To Payer

FORM 23

Dept. Form [illegible]

REQUEST AND AUTHORIZATION TO INCUR EXPENSE

Department of Justice

__________ District of __________

TO: THE ADMINISTRATIVE ASSISTANT ATTORNEY GENERAL,
Washington, D.C.

____
(Place and date)

FROM: __________
(Name—please type)

____
(Title)

____
(Signature)

DJ File No. __________

RE: __________

____

REQUEST

Authority is hereby requested to incur the expense described below:

Estimated total expense: $__________

Contract No. __________

NOTE.—Instructions on the reverse hereof must be complied with fully.

AUTHORIZATION

You are authorized to incur above-mentioned expense. Date __________

☐ Payment should be made by the U. S. Marshal for your district from the appropriation.

☐ Voucher should be forwarded to this office for payment from the appropriation.

Recommendation for Approval:

Approved:

____
Administrative Assistant Attorney General.

Form 23a **VE**

STANDARD FORM 143 APRIL 1953 GENERAL SERVICES ADMINISTRATION GENERAL REGULATION NO. 14 — **ORDER FOR TELEPHONE SERVICE**	1. ORDER NO.	2. DATE	DO NOT USE THIS SPACE ORDER NO.
3. TO	4. FROM		

5. OFFICE FOR WHICH THE FOLLOWING TELEPHONE SERVICE IS REQUIRED FOR OFFICIAL USE (*Organizational Unit*)

6. CONNECT						DISCONNECT					
MAIN EXTENSION NO.	BRIDGED EXTS.	ASSOCIATED EQUIPMENT			BUILDING AND ROOM NO.	MAIN EXTENSION NO.	BRIDGED EXTS.	ASSOCIATED EQUIPMENT			BUILDING AND ROOM NO.
		NO.	TYPE	PICKUP MAIN EXTS.				NO.	TYPE	PICKUP MAIN EXTS.	

7. REMARKS

8. APPROPRIATION		9. IS FURNITURE MOVING FORCE TO BE USED? ☐ YES ☐ NO	10. WILL THIS ORDER REQUIRE A CHANGE IN DIRECTORY LISTING? (*If "Yes," attach Standard Form [illegible], showing changes desired*) ☐ YES ☐ NO
11. INSTALLER SEE	A. ROOM NO. B. EXTENSION NO.	12. SIGNATURE AND TITLE OF REQUISITIONING OFFICER	A. ROOM NO. B. EXTENSION NO.
13. DATE SERVICE DESIRED	14. AGENCY TELEPHONE NO.	15. SIGNATURE AND TITLE OF AUTHORIZING OFFICER	

DISTRIBUTION OF COPIES

16—[illegible]-1 U. S. GOVERNMENT PRINTING OFFICE

FORM 24 (face)

Standard Form No. 1034
7 GAO 1000
1034-110

PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL

U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION

DATE VOUCHER PREPARED

CONTRACT NUMBER AND DATE

REQUISITION NUMBER AND DATE

VOUCHER NUMBER

PAID BY

PAYEE'S NAME AND ADDRESS

DATE INVOICE RECEIVED

DISCOUNT TERMS

PAYEE'S ACCOUNT NUMBER

SHIPPED FROM | TO | WEIGHT

GOVERNMENT B/L NUMBER

NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES (*Enter description, item number of contract or Federal supply schedule, and other information deemed necessary*)	QUANTITY	UNIT PRICE		AMOUNT
				COST	PER	[1]

(Use continuation sheet(s) if necessary) **(Payee must NOT use the space below)** **TOTAL**

PAYMENT:
- COMPLETE
- PARTIAL
- FINAL
- PROGRESS
- ADVANCE

APPROVED FOR = $

EXCHANGE RATE = $1.00

DIFFERENCES

BY [2]

TITLE

Amount verified; correct for

(*Signature or initials*)

Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.

(*Date*) (*Authorized Certifying Officer*) [2] (*Title*)

ACCOUNTING CLASSIFICATION (*Appropriation symbol must be shown: other classification optional*)

PAID BY

CHECK NUMBER	ON TREASURER OF THE UNITED STATES	CHECK NUMBER	ON (*Name of bank*)
CASH $	DATE	PAYEE [3]	

[1] When stated in foreign currency, insert name of currency.
[2] If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the space provided, over his official title.
[3] When a voucher is receipted in the name of a company or corporation, the name of the person writing the company or corporate name, as well as the capacity in which he signs, must appear. For example: "John Doe Company, per John Smith, Secretary", or "Treasurer", as the case may be.

PER

TITLE

GPO : 1963 OF—[illegible]

FORM 25 (face)

Standard Form No. 1128
5 GAO 6000
1128-103

PAGE 1

PAYROLL FOR PERSONAL SERVICES

PAYROLL CERTIFICATION AND SUMMARY

Voucher No. 139

Department of Justice
(Department or establishment)
United States Attorney
(Bureau, division, or office)
Anytown, Anystate
(Location)

Period of this roll: From Feb. 4, 1962 To Feb. 17, 1962

PAID BY
Job Tubbs
U. S. Marshal
Any District-Any State
Symbol 8100

Certification

Date February 23, 1962

Pursuant to authority vested in me I certify that the within payroll, in one pages, is correct and proper for payment.

This roll approved for $ 1,513.65

/s/ Samuel Brown
(Signature of certifying officer)
Authorized Certifying Officer
(Official title)

PAYROLL SUMMARY

	AMOUNT	CHECK NOS.
Net payment to employees (*as per attached lists*)	1,082.19	x x x x x x x x x x x
Other items requiring disbursement:		
Civil Service Retirement, Employees'	36.29	
Civil Service Retirement, Employer's	36.29	
Federal Withholding Tax	226.60	
U. S. Savings Bonds	45.00	
Federal Insurance Contributions Act, Employees' Tax	27.50	
Federal Insurance Contributions Act, Employer's Tax	27.50	
State Withholding Tax		
Group Life Insurance, Employees'	5.25	
Group Life Insurance, Employer's	2.62	
Health Benefits, Employees'	15.57	
Health Benefits, Employer's	8.84	
Other (*itemize*):		
GROSS PAYMENTS	1,513.65	
Other items not requiring disbursement (*subsistence, etc.*):		
		x x x x x x x x x x x
		x x x x x x x x x x x
GROSS EARNINGS		x x x x x x x x x x x

ACCOUNTING CLASSIFICATION (Appropriation Symbol must be shown; other classification optional)

A-1520322 $1,513.65

FORM 25 (back)

NAME, GRADE, DESIGNATION, TOTAL SALARY RATE, AND HEALTH BENEFITS CODE	GROSS AMOUNT EARNED	DEDUCTIONS								NET AMOUNT PAID	CHECK NO. CHANGE SLIP NO. OR REMARKS
		Ret.	Federal Tax	Bonds	FICA	State Tax	Group Life Ins.	Health Benefits			
Brown, Samuel (2) Unclassified U.S. Attorney $19,500	712.00		119.00	18.75	22.25		W	5.82		546.18	* 7346
Burbank, Luther (4) Unclassified A.U.S. Attorney $10,200	392.80	25.53	51.70	18.75			2.75	5.82		288.25	7347
Green, Clarice (1) GS-3 Clerk $4285	165.60	10.76	25.30	3.75			1.25	1.82		122.72	7348
White, Pauline (0) GS-4 Clerk $4355	168.00		30.60	3.75	5.25		1.25	2.11		125.04	Fanfold 9421 7349
Total	1438.40	36.29	226.60	45.00	27.50		5.25	15.57		1082.19	
Agency Contributions	75.25	36.29			27.50		2.62	8.84			
Total	1513.65	72.58	226.60	45.00	55.00		7.87	24.41		1082.19	
Earnings subject to FICA	880.00										
" not " " "	558.40										
	1438.40										

* Check numbers are inserted by Marshal at time of payment.

TITLE 8: ADMINISTRATIVE DIVISION

FORM 26 (face)

STANDARD FORM NO. 1012
7 GAO 3500
1012-105

(Travel Outside District)

TRAVEL VOUCHER

DEPARTMENT, BUREAU, OR ESTABLISHMENT: Justice - U. S. Attorney

VOUCHER NO.:

PAYEE'S NAME: Joe Dokes

PAID BY:

MAILING ADDRESS: United States Attorneys Office
Federal Building
Cleveland, Ohio

OFFICIAL DUTY STATION: Cleveland, Ohio

RESIDENCE: Cleveland, Ohio

FOR TRAVEL AND OTHER EXPENSES — FROM (DATE): 9/5/62 — TO (DATE): 9/11/62

APPLICABLE TRAVEL AUTHORIZATION(S) — NO.: 785 — DATE: 8/30/62

TRAVEL ADVANCE — Outstanding: $ — Amount to be applied: — Balance to remain outstanding: $

CHECK NO.:

CASH PAYMENT RECEIVED: (DATE) (SIGNATURE OF PAYEE)

TRANSPORTATION REQUESTS ISSUED

TRANSPORTATION REQUEST NUMBER	AGENT'S VALUATION OF TICKET	INITIALS OF CARRIER ISSUING TICKET	MODE, CLASS OF SERVICE, AND ACCOMMODATIONS*	DATE ISSUED	POINTS OF TRAVEL FROM—	POINTS OF TRAVEL TO—
A-1,234,567	39.20	N.W.A.L.	Coach	9/5/62	Cleveland, Ohio	Washington, D.C. and return

** *Certified correct. Payment or credit has not been received.*

9/21/62 (Date) — /S/ Joe Dokes (Signature of Payee)

AMOUNT CLAIMED	Dollars	Cts
→	109	50

APPROVED (*Supervisory and other approvals when required*)

DIFFERENCES:

NEXT PREVIOUS VOUCHER PAID UNDER SAME TRAVEL AUTHORITY — VOUCHER NO. — D.O. SYMBOL — DATE (MONTH-YEAR)

Total verified correct for charge to appropriation(s)

Certified correct and proper for payment:

Applied to travel advance (appropriation symbol)

9/21/62 (Date) — /S/ John Doe
John Doe (Authorized Certifying Officer) U.S. Attorney

NET TO TRAVELER →

ACCOUNTING CLASSIFICATION (*Appropriation symbol must be shown; other classification optional*)

A-1530322 — $109.50

* Abbreviations for Pullman accommodations: MR, master room; DR, drawing room; CP, compartment; BR, bedroom; DSR, duplex single room; RM, roomette; DRM, duplex roomette; SOS, single occupancy section; LB, lower berth; UB, upper berth; LB-UB, lower and upper berth; S, seat.

** FRAUDULENT CLAIM—*Falsification of an item in an expense account works a forfeiture of the claim (28 U.S.C. 2514) and may result in a fine of not more than $10,000 or imprisonment for not more than 5 years or both (18 U.S.C. 287; id. 1001).*

TITLE 8: ADMINISTRATIVE DIVISION

FORM 26 (back)

SCHEDULE OF EXPENSES AND AMOUNTS CLAIMED

PREVIOUS TEMPORARY DUTY *(Complete these blocks only if in travel status immediately prior to period covered by this voucher and if administratively required)*

DEPARTURE FROM OFFICIAL STATION (DATE)	(HOUR)	TEMPORARY DUTY STATION LAST DAY OF PRECEDING VOUCHER PERIOD (LOCATION)	(DATE OF ARRIVAL)

DATE 19 62	NATURE OF EXPENSE	AUTHORIZED MILEAGE RATE ____¢		AMOUNT CLAIMED					
		Speedometer Readings	No. of Miles	Mileage		Subsistence		Other	
9/5	Taxi, Res. to Airport							1	25
	Departed Cleveland 9:00 A.M.								
	Arrived D. C. 10:15 A.M.								
	Taxi, Airport to Hotel							1	75
9/6 to 9/10	O.B. Washington, D. C.								
9/11	Taxi, Hotel to Airport							1	75
	Departed Washington, D. C. 12 Noon								
	Arrived Cleveland 1:15 P.M.								
	Taxi, Airport to Office								75
	Per Diem:								
	9:00 A.M. 9/5/62 to 1:15 P.M. 9/11/62								
	6 1/2 days @ $16.00					104	00		
	Grand total to face of voucher (Subtotals, to be carried forward if necessary) →	$109.50				104	00	5	50

FORM 26 (face)

STANDARD FORM NO. 1012
7 GAO 3500
1012-105

(Within District)
TRAVEL VOUCHER

DEPARTMENT, BUREAU, OR ESTABLISHMENT: Justice - U. S. Attorney

VOUCHER NO.:

PAYEE'S NAME: John Doe

PAID BY:

MAILING ADDRESS: United States Attorneys Office
Federal Building
Cleveland, Ohio

OFFICIAL DUTY STATION: Cleveland

RESIDENCE: Cleveland

FOR TRAVEL AND OTHER EXPENSES

FROM (DATE)	TO (DATE)
10/1/62	10/5/62

APPLICABLE TRAVEL AUTHORIZATION(S)
NO. DATE
Title 8:109 U. S. Att. Man.

TRAVEL ADVANCE

Outstanding	$
Amount to be applied	
Balance to remain outstanding	$

CHECK NO.:

CASH PAYMENT RECEIVED:

(DATE) (SIGNATURE OF PAYEE)

TRANSPORTATION REQUESTS ISSUED

TRANSPORTATION REQUEST NUMBER	AGENT'S VALUATION OF TICKET	INITIALS OF CARRIER ISSUING TICKET	MODE, CLASS OF SERVICE, AND ACCOMMODATIONS *	DATE ISSUED	POINTS OF TRAVEL FROM—	POINTS OF TRAVEL TO—

** *Certified correct. Payment or credit has not been received.*

10/5/62 /S/ John Doe
(Date) (Signature of Payee)

AMOUNT CLAIMED	Dollars	Cts
→	90	00

APPROVED *(Supervisory and other approvals when required)*

DIFFERENCES:

NEXT PREVIOUS VOUCHER PAID UNDER SAME TRAVEL AUTHORITY

VOUCHER NO.	D.O. SYMBOL	DATE (MONTH-YEAR)

Total verified correct for charge to appropriation(s)

Certified correct and proper for payment:

Applied to travel advance (appropriation symbol)

10/5/62 Mable Smith
(Date) (Authorized Certifying Officer)

NET TO TRAVELER →

ACCOUNTING CLASSIFICATION *(Appropriation symbol must be shown; other classification optional)*

1530322 $90.00

* Abbreviations for Pullman accommodations: MR, master room; DR, drawing room; CP, compartment; BR, bedroom; DSR, duplex single room; RM, roomette; DRM, duplex roomette; SOS, single occupancy section; LB, lower berth; UB, upper berth; LB-UB, lower and upper berth; S, seat.

** FRAUDULENT CLAIM—Falsification of an item in an expense account works a forfeiture of the claim (28 U.S.C. 2514) and may result in a fine of not more than $10,000 or imprisonment for not more than 5 years or both (18 U.S.C. 287; *id.* 1001).

TITLE 8: ADMINISTRATIVE DIVISION

FORM 26 (back)

SCHEDULE OF EXPENSES AND AMOUNTS CLAIMED

PREVIOUS TEMPORARY DUTY *(Complete these blocks only if in travel status immediately prior to period covered by this voucher and if administratively required)*

DEPARTURE FROM OFFICIAL STATION (DATE)	(HOUR)	TEMPORARY DUTY STATION LAST DAY OF PRECEDING VOUCHER PERIOD (LOCATION)	(DATE OF ARRIVAL)

DATE 19 62	NATURE OF EXPENSE	AUTHORIZED MILEAGE RATE ____¢		AMOUNT CLAIMED					
		Speedometer Readings	No. of Miles	Mileage		Subsistence		Other	
10/1	Departed Cleveland *2:00 P.M.	1867							
	Arrive Toledo 4:15 P.M.	1978	111	11	10				
	*Early departure to confer with								
	Court Officials								
10/2-4	Attending Court								
10/5	Depart Toledo 11:45 A.M.	2256							
	Arrive Cleveland 2:30 P.M.	2365	109	10	90				
	Per Diem 2:00 10/1 to 2:30 P.M. 10/5								
	4 1/4 @ $16.00					68	00		
	Grand total to face of voucher (Subtotals, to be carried forward if necessary) →	$90.00		22	00	68	00		

U.S. GOVERNMENT PRINTING OFFICE

FORM 27 (face)

Form No. DJ-20
(Rev. 4-25-61)

REQUISITION - INVOICE

DEPARTMENT OF JUSTICE

REQUISITION DATE	PAGE NO.	NO. OF PAGES	REGULAR ☐ SPECIAL ☐	(PLEASE JUSTIFY SPECIAL)	REQUISITION INVOICE NO. 21204

TO:
CHIEF, SUPPLIES and PRINTING SECTION
DEPARTMENT OF JUSTICE
10th & PENNA. AVE., N.W.
WASHINGTON 25, D.C.

FROM:
OFFICE OF ______
SIGNATURE ______
OFFICIAL TITLE ______
BUILDING OR STREET AND NO. ______
CITY ______ STATE ______

ALWAYS REFER TO THIS NUMBER IN ALL CORRESPONDENCE CONCERNING THIS REQUISITION

SUPPLIES AND PRINTING SECTION USE ONLY

ITEM OR FORM NO.	DESCRIPTION	QUANTITY ON HAND	QUANTITY ORDERED	UNIT	TOTAL COST	QUANTITY SHIPPED	ACTION CODE	BACK ORD.

NOTE
SEE INSTRUCTIONS IN THE DEPARTMENT'S SUPPLY CATALOG.

DATE SHIPPED		METHOD OF SHIPMENT
CHECKER	PACKER	GOVT. B/L NO. J-

UNITS SHIPPED

TYPE	NUMBER	WEIGHT
CARTONS		
CASES		
PACKAGES		

KEY TO ACTION CODE →	S-Substituted Item	Q-Quantity Reduced	C-Cancelled. Order From GSA
NO CODE—Shipped as Ordered	B-Previously Backordered	A-Action Pending	G-Item Being Ordered From GSA

A.
ORIGINAL COPY

Title 8

Note:

The Page 186 was not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 28

FORM NO. DJ-[illegible]
EXCEPTION TO S. F. 50 APPROVED
BY BUREAU OF THE BUDGET
DECEMBER 1963

NOTIFICATION OF PERSONNEL ACTION

7 PART
50-110

(For agency use)

1. NAME (CAPS) LAST–FIRST–MIDDLE MR.–MISS–MRS.
2. (For agency use)
3. BIRTH DATE (Mo., Day, Year)
4. SOCIAL SECURITY NO.

5. VETERAN PREFERENCE
1–NO 2–5 PT. 3–10 PT. DISAB. 4–10 PT. COMP. 5–10 PT. OTHER
6. TENURE GROUP
7. SERVICE COMP. DATE
8. PHYSICAL HANDICAP CODE

9. FEGLI
1–COVERED 2–INELIGIBLE 3–WAIVED
10. RETIREMENT
1–CS 2–FICA 3–FS 4–NONE 5–OTHER
11. (For CSC use)

12. NATURE OF ACTION
CODE
13. EFFECTIVE DATE (Mo., Day, Year)
14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY

15. FROM: POSITION TITLE AND NUMBER
16. PAY PLAN AND OCCUPATION CODE
17. GRADE OR LEVEL
18. SALARY

19. NAME AND LOCATION OF EMPLOYING OFFICE

20. TO: POSITION TITLE AND NUMBER
21. PAY PLAN AND OCCUPATION CODE
22. GRADE OR LEVEL
23. SALARY

24. NAME AND LOCATION OF EMPLOYING OFFICE

25. DUTY STATION (City–county–State)
26. LOCATION CODE

27. APPROPRIATION
28. POSITION OCCUPIED
1–COMPETITIVE SERVICE 2–EXCEPTED SERVICE
29. APPORTIONED POSITION
FROM: TO: STATE
1–PROVED–1 2–WAIVED–2

30. REMARKS
☐ A. SUBJECT TO COMPLETION OF 1 YEAR PROBATIONARY (OR TRIAL) PERIOD COMMENCING ____________
☐ B. SERVICE COUNTING TOWARD CAREER (OR PERMANENT) TENURE FROM: ____________

SEPARATIONS: SHOW REASONS BELOW, AS REQUIRED. CHECK IF APPLICABLE: ☐ C. DURING PROBATION ☐ D. FROM APPOINTMENT OF 6 MONTHS OR LESS

PAYROLL CHANGE DATA												
	BASE PAY	OVERTIME		GROSS PAY	RET.	FEDERAL TAX	BOND	F. I. C. A.	STATE TAX	GROUP LIFE INS.		NET PAY
7. Previous period												
8. New period												
9. Pay this period												

31. DATE OF APPOINTMENT AFFIDAVIT (Accessions only)
34. SIGNATURE (Or other authentication) AND TITLE
BY DIRECTION OF THE ATTORNEY GENERAL--

32. OFFICE MAINTAINING PERSONNEL FOLDER
(If different from employing office) Personnel Office, Room 1230
Department of Justice, Washington 25, D.C.

33. CODE EMPLOYING DEPARTMENT OR AGENCY
DEPARTMENT OF JUSTICE
35. DATE
ADMINISTRATIVE ASSISTANT ATTORNEY GENERAL

2. PAYROLL COPY

FORM 29

ANNUAL LEAVE CEILING COMPUTATION
(Based on yearly accrual of 20 days -- 3-15 years' service)

1. The method for computing annual leave for employees having 60 days or more as of December 21, 1952 is as follows:

	Days	Hours
Accumulated 12/21/52	60	0
Earned 12/21/52 thru 12/19/53	20	0
	80	0
Used in 1953 to present date	11	0
	69	0
Carry forward as of 12/20/53	60	0
To use by 12/19/53 or forfeit	9	0

2. Employees having less than 60 days as of December 21, 1952 whose 1953 annual leave accruals bring their balances to over 60 days are computed as follows:

	Days	Hours	Days	Hours	
Accumulated 12/21/52	48	0	20	0	earned.
Earned 12/21/52 thru 12/19/53	20	0	5	2	used to present date.
	68	0			
Used to present date	5	2	14	6	left to use.
	62	6	2	6	must be used by 12/19/53.
Maximum	60	0			
To be used by 12/19/53	2	6	12	0	must be taken by 6/30/54
Balance to be carried forward 12/20/53	48	0			

3. Where balance will not exceed 60 days in any event as follows:

	Days	Hours
Accumulated 12/21/52	15	0
Earned 12/21/52 to 12/19/53	20	0
	35	0
Used to present date	10	0
	25	0
Carry forward 12/20/53	15	0
To be used by 6/30/54	10	0

FORM 30 (face)

STANDARD FORM 15
DECEMBER [illegible]
CIVIL SERVICE COMMISSION
FPM CHAPTER VI

VETERAN PREFERENCE CLAIM

15-102-01

INSTRUCTIONS: All preference claimants must fill in questions 1–21 and sign part 5. Claimants should read the instructions on the reverse side of this form to see what other requirements *they* must fulfill.

PART 1 — All preference claimants

1. NAME OF VETERAN ON WHOSE SERVICE PREFERENCE IS CLAIMED (*exactly as it appears on discharge form*)
2. VETERAN'S DATE OF BIRTH (*mo., day, yr.*)
3. IS THE VETERAN DECEASED? ☐ YES ☐ NO — *If deceased, give date of death:*
4. GIVE CLAIM NUMBER IF VETERAN HAS AN EXISTING DISABILITY RECOGNIZED BY VETERANS ADMINISTRATION AS SERVICE-CONNECTED, OR IF HE IS RECEIVING COMPENSATION, PENSION, OR DISABILITY RETIREMENT BENEFITS FROM THAT AGENCY — CLAIM NO. ______
5. IS VETERAN RECEIVING DISABILITY RETIREMENT BENEFITS FROM A BRANCH OF THE ARMED FORCES? YES ☐ NO ☐
6. HAS VETERAN BEEN AWARDED THE PURPLE HEART FOR WOUNDS OR INJURIES RECEIVED IN ACTION? YES ☐ NO ☐
7. YOUR NAME (*First*) (*Middle*) (*Last*)
8. YOUR ADDRESS
9. YOUR DATE OF BIRTH (*mo., day, year*)
10. WHICH ARE YOU? (*check one*) ☐ THE VETERAN ☐ THE VETERAN'S WIDOW ☐ THE WIFE OF A DISABLED VETERAN ☐ THE MOTHER OF A DECEASED OR DISABLED VETERAN
11. TITLE OF EXAMINATION FOR WHICH THIS FORM IS SUBMITTED
12. ANNOUNCEMENT NO.
13. DATE TEST HELD OR APPLICATION FILED
14. RATING, IF KNOWN
15. WAS THE VETERAN'S SERVICE IN PEACETIME ONLY? YES ☐ NO ☐
16. IF ANSWER TO QUESTION 15 IS "YES," WAS CAMPAIGN OR SERVICE MEDAL AUTHORIZED? YES ☐ NO ☐
17. BRANCH OF SERVICE
18. SERIAL OR SERVICE NUMBER (*if none, give grade or rating*)
19. DATE OF ENTRY(IES) INTO ARMED FORCES
20. DATE OF SEPARATION(S) FROM ARMED FORCES
21. WAS THE SEPARATION HONORABLE? ☐ YES ☐ NO

PART 2 — Wives and widows

22. DATE YOU MARRIED VETERAN
23. ARE YOU (*or were you before his death*) DIVORCED FROM THE VETERAN? YES ☐ NO ☐
24. DATE OF DIVORCE
25. IF WIDOWED OR DIVORCED FROM VETERAN HUSBAND, HAVE YOU REMARRIED? YES ☐ NO ☐

PART 3 — Mothers of deceased or disabled veterans

26. IS THE VETERAN YOUR NATURAL CHILD? (*Preference cannot be granted on the service of a stepchild, foster child, or adopted child*) YES ☐ NO ☐
27. IS THE NATURAL FATHER OF YOUR CHILD (*check one*) ☐ LIVING WITH YOU? ☐ DECEASED? ☐ DIVORCED FROM YOU? ☐ SEPARATED FROM YOU?
28. IS THE NATURAL FATHER OF YOUR CHILD (*or the husband of your remarriage*) WITH WHOM YOU ARE NOW LIVING TOTALLY AND PERMANENTLY DISABLED (*See instruction C*)? YES ☐ NO ☐
29. IF NATURAL FATHER OF VETERAN IS DECEASED OR DIVORCED FROM YOU, HAVE YOU REMARRIED? YES ☐ NO ☐
30. ARE YOU WIDOWED, DIVORCED, OR LEGALLY SEPARATED FROM THE HUSBAND OF YOUR REMARRIAGE? YES ☐ NO ☐

PART 4 — Wives or mothers of disabled veterans

31. IS VETERAN NOW EMPLOYED — FULL-TIME? YES ☐ NO ☐ PART-TIME? YES ☐ NO ☐
32. IF THE VETERAN IS NOW EMPLOYED PART-TIME, CHECK THE BOX BELOW WHICH BEST INDICATES THE EXTENT OF PART-TIME EMPLOYMENT ☐ REGULAR, ½-TIME OR MORE ☐ REGULAR, LESS THAN ½-TIME ☐ OCCASIONAL
33. NATURE OF VETERAN'S EMPLOYMENT BEFORE MILITARY SERVICE, IF ANY (*such as porter, bond salesman, radio mechanic, etc.*)
34. NATURE OF VETERAN'S PRESENT OR MOST RECENT EMPLOYMENT SUBSEQUENT TO MILITARY SERVICE (*such as porter, bond salesman, radio mechanic, etc.*)
35. IF VETERAN HAS APPLIED FOR FEDERAL CIVIL SERVICE EXAMINATION IN PAST 3 YEARS, GIVE: TITLE OF EXAMINATION — DATE TEST HELD OR APPLICATION FILED — RATING, IF KNOWN
36. IF VETERAN HAS BEEN EMPLOYED IN FEDERAL CIVIL SERVICE IN PAST 3 YEARS, GIVE: TITLE AND GRADE OF POSITION — NAME AND ADDRESS OF AGENCY

PART 5 — All preference claimants must sign here

I CERTIFY that the statements made by me in answer to the foregoing questions are true to the best of my knowledge and belief.

DATE | SIGNATURE

Be sure to attach the proof called for on the other side. Preference cannot be allowed unless required proof is furnished

(OVER)

FORM [illegible] (back)

HOW TO APPLY FOR VETERAN PREFERENCE

	Fill in on other side of this form	Attach proof called for below
Veteran of Wartime Service, Not Claiming Disability Preference	Parts 1, 5	Proof A
Veteran of Peacetime Service, Not Claiming Disability Preference	Parts 1, 5	Proof A, B
Veteran With Service-Connected Disability	Parts 1, 5	Proof A, C
Veteran Receiving Non-Service-Connected Pension or Retirement Benefit	Parts 1, 5	Proof A, E
Wife of a Veteran With Service-Connected Disability	Parts 1, 2, 4, 5	Proof A, D
Widow of a Deceased Veteran	Parts 1, 2, 5	Proof A or F
Mother of a Deceased Veteran	Parts 1, 3, 5	Proof A or F (and G in proper cases)
Mother of a Disabled Veteran	Parts 1, 3, 4, 5	Proof A, D (and G in proper cases)

PROOF REQUIRED—READ CAREFULLY

(Documents Submitted as Proof Will be Returned)

A. EVERY PREFERENCE CLAIMANT must furnish proof of the veteran's honorable separation from a recognizable period of active duty with the Armed Forces that meets the requirements of the type of preference claimed. (The Armed Forces include the Army, Navy, Air Forces, Marine Corps, Coast Guard, and during time of war, certain personnel of the Public Health Service and the Coast and Geodetic Survey.) Any of the documents listed below may be submitted as proof, provided they are dated on or after the day of separation from active service. Certified or photostatic copies are acceptable.

1. Honorable discharge certificate.
2. Certificate of transfer to Fleet Naval or Marine Corps Reserve.
3. Certificate of transfer to Enlisted Reserve Corps.
4. Orders of Transfer to Retired List.
5. Report of Separation from Service Department, provided honorable separation is shown.
6. Certificate of Service or release from Active duty.
7. Official Statement from Service Department that honorable separation was effected.
8. Notation by Veterans Administration on official statement described in C (*a*) or (*b*) below that veteran was honorably separated from military service.
9. Notification by the Civil Service Commission of previous allowance of preference. (NOTE: Preference is allowable only if present service requirements are met.)
10. Notice of death as provided for in F below.

B. NONDISABLED VETERAN WHOSE ONLY SERVICE WAS IN PEACETIME must submit, in addition to proof of honorable discharge, proof that the active peacetime service was performed in a campaign or expedition for which a campaign badge or service medal was authorized. This proof consists of the official notification by the Service Department of the award of the Service Medal. If the official notification of the American Defense Service Medal for active duty between September 8, 1939, and December 8, 1941, is submitted, submit also the official notification of the award of service clasp or bronze star for service outside the continental United States. Do not submit the actual badge or medal.

C. VETERAN CLAIMING PREFERENCE BECAUSE OF SERVICE-CONNECTED DISABILITY must submit, in addition to proof of honorable separation, one of the documents listed below:

(*a*) An official statement, ***dated within 6 months***, from the Veterans Administration or from a Service Department, certifying to the present existence of the veteran's service-connected disability.

(*b*) An official statement, ***dated within 6 months***, from the Veterans Administration, certifying to the veteran's present receipt of compensation or service-connected disability retired pay.

(*c*) An official statement, ***dated within 6 months***, from a Service Department certifying to the veteran's present receipt of service-connected disability retired pay.

(*d*) An official statement, ***dated within 6 months***, from a Service Department certifying to the veteran's present receipt of service-connected disability retired pay for a disability of 10% or more.

(*e*) An official citation, issued by a Service Department, of the award to the veteran of the Purple Heart for wounds or injuries received in action.

While the documents described in any one of the above categories (*a*), (*b*), (*c*), (*d*), or (*e*) are sufficient to establish 10 point disability preference, the material specified in either (*b*) or (*d*) must be submitted in order to obtain the full benefits available to persons entitled to compensable preference.

D. WIFE OR MOTHER CLAIMING PREFERENCE ON BASIS OF SERVICE-CONNECTED DISABILITY OF HUSBAND, SON, OR DAUGHTER, must submit, in addition to proof of honorable discharge, one of the documents listed under C above. If the veteran is receiving retirement pay from the Armed Forces because of service-connected disability, the wife or mother must also submit an official statement showing nature and extent of the service-connected disability. Service Departments will furnish such statements to the veteran upon request.

NOTE: The wife or mother of a disabled veteran is eligible for preference only if such veteran is disqualified by reason of a service-connected disability for a position along the lines of his usual occupation. Mother preference can be awarded only if the disability of the veteran son or daughter is rated permanent and total.

E. VETERAN CLAIMING PREFERENCE BECAUSE OF NON-SERVICE-CONNECTED DISABILITY PENSION OR RETIREMENT BENEFIT must submit, in addition to proof of honorable discharge, either:

(*a*) An official statement from, or official notice of award of pension by, the Veterans Administration showing present payment to the veteran of non-service-connected disability pension; or

(*b*) An official statement from, or official notice of award of disability retired pay by, a Service Department showing payment to the veteran of such pay.

F. WIDOW OR MOTHER OF A DECEASED VETERAN must, if the death of the ex-service husband, son or daughter occurred under honorable conditions while he was serving on active duty, during any war, submit the official notice from the Service Department showing the date the husband, son or daughter died. If the active duty was not in a war, but was in a campaign for which a service medal was authorized, the official notification of the service medal must be submitted in addition to the official notice of death (see B above for details). A claim from a mother of a deceased veteran can be considered only if such veteran's death occurred ***while he was serving on active duty during a war or in a campaign or expedition for which a campaign badge or service medal was authorized.***

G. DECEASED OR DISABLED VETERAN'S MOTHER CLAIMING PREFERENCE BECAUSE OF HER HUSBAND'S TOTAL AND PERMANENT DISABILITY must submit, in addition to the proof required under F or A and C above, a statement from her husband's physician showing prognosis of his disease and percentage of his disability.

U.S. GOVERNMENT PRINTING OFFICE : 1961 O—[illegible]

FORM 31

Optional Form 8
July 1966
U. S. CIVIL SERVICE COMMISSION
Chapter P2, Federal Personnel Manual
[illegible]

POSITION DESCRIPTION

1. Check one: Dept'l ☐ Field ☐

2. Official headquarters:

3. Reason for submission:
(a) If this position replaces another (i. e., a change of duties in an existing position), identify such position by title, allocation (service, series, grade), and position number

(b) Other (specify)

4. Agency position No.

5. C. S. C. certification No.

6. Date of certification

7. Date received from C. S. C.

8. CLASSIFICATION ACTION

ALLOCATION BY	CLASS TITLE OF POSITION	CLASS			INITIALS	DATE
		Service	Series	Grade		
a. Civil Service Commission						
b. Department, agency, or establishment						
c. Bureau						
d. Field office						
e. Recommended by initiating office						

9. Organizational title of position (if any)

10. Name of employee (if vacant, specify V-1, 2, 3, or 4)

11. Department, agency, or establishment

a. First subdivision

b. Second subdivision

c. Third subdivision

d. Fourth subdivision

e. Fifth subdivision

12. This is a complete and accurate description of the duties and responsibilities of my position

(Signature of employee) (Date)

13. This is a complete and accurate description of the duties and responsibilities of this position

(Signature of immediate supervisor) (Date)

Title:

14. Certification by head of bureau, division, field office, or designated representative

(Signature) (Date)

Title:

15. Certification by department, agency, or establishment

(Signature) (Date)

Title:

16. Description of duties and responsibilities

If more space is required, use the other side and additional pages size 8 x 10½

GPO : [illegible]—O—[illegible]

FORM 32 (face of original)

Standard Form No. 1152
Form prescribed by
Comptroller General, U. S.
October 23, 1950
(Gen. Reg. No. 104, Supp. No. 1)

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF DECEASED CIVILIAN EMPLOYEE

IMPORTANT
Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME— (Last) (First) (Middle) | DATE OF BIRTH (Month, day, year)

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency) (Bureau) (Division)

I, the employee identified above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION *due and payable under existing law after my death. I understand that this Designation of Beneficiary relates solely to Unpaid Compensation as defined in section 2 of the act of August 3, 1950, Public Law 636, and in nowise will affect the disposition of any benefit which may become payable under the Retirement Act applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect, unless or until canceled by me in writing, so long as I am continuously employed in the above department or agency.*

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary at any time in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

(Date of execution—month, day, year) (Signature of employee)

WITNESSES TO SIGNATURE:

(Signature of witness) (Number and street) (City, zone number, and State)

(Signature of witness) (Number and street) (City, zone number, and State)

PRINT OR TYPE NAME AND ADDRESS OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY—DUPLICATE WILL BE NOTED AND RETURNED

16—60010-1

FORM 32 (back of original)

IMPORTANT.—The filing of this form will completely cancel any designation you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any unpaid compensation payable at your death.

EXAMPLES OF DESIGNATIONS

How To Designate One Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Catherine M. Jackson*	2808 Southern Avenue, Williams, Ind.	Sister	All

How To Designate More Than One Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Susan L. Brown**	110 Prince Street, Anniston, N. Y.	Aunt	One-fourth
Mary Joe Carson	230 Duke Street, Anniston, N. Y.	Niece	One-fourth
Elizabeth M. Howard	2301 State Street, Weaver, Ohio	Mother	One-half

How To Designate a Contingent Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
William J. Johnson, if living	244 South Ann Street, Olney, Ga.	Father	All
Otherwise to: Sarah L. Johnson	244 South Ann Street, Olney, Ga.	Sister	All

How To Cancel a Designation of Beneficiary so That Amount Due Will Be Payable as Provided by the Law

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Cancel prior designations			

*Do not write name as C. M. Jackson or as Mrs. John M. Jackson.
**Be sure that the shares to be paid to the several beneficiaries add up to 100 percent.

[illegible]

FORM 32 (face of duplicate)

Standard Form No. 1152
Form prescribed by
Comptroller General, U. S.
October [illegible]
(Gen. Reg. No. 104, Supp. No. 1)

DESIGNATION OF BENEFICIARY

UNPAID COMPENSATION OF
DECEASED CIVILIAN EMPLOYEE

IMPORTANT
Read instructions
on back of duplicate
before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME— (Last) (First) (Middle) | Date of Birth (Month, day, year)

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency) (Bureau) (Division)

I, the employee identified above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION *due and payable under existing law after my death. I understand that this Designation of Beneficiary relates solely to Unpaid Compensation as defined in section 2 of the act of August 3, 1950, Public Law 636, and in nowise will affect the disposition of any benefit which may become payable under the Retirement Act applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect, unless or until canceled by me in writing, so long as I am continuously employed in the above department or agency.*

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary at any time in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

(Date of execution—month, day, year) (Signature of employee)

WITNESSES TO SIGNATURE:

(Signature of witness) (Number and street) (City, zone number, and State)

(Signature of witness) (Number and street) (City, zone number, and State)

PRINT OR TYPE NAME AND ADDRESS OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY—DUPLICATE WILL BE NOTED AND RETURNED

16—[illegible]

DUPLICATE

FORM 32 (back of duplicate)

IMPORTANT NOTICE—*Order of Precedence*

If there is no designated beneficiary living, any unpaid compensation which becomes payable after the death of an employee will be payable to the first person or persons listed below who are alive on the date title to the payment arises.

1. To the widow or widower.

2. If neither of the above, to the child or children in equal shares, with the share of any deceased child distributed among the descendants of that child.

3. If none of the above, to the parents in equal shares or the entire amount to the surviving parent.

4. If there be none of the above, to the duly appointed legal representative of the estate of the deceased employee, or if there be none, to the person or persons determined to be entitled thereto under the laws of the domicile of the deceased employee.

It is not necessary for any employee to designate a beneficiary unless he wishes to name some person or persons not included above, or in a different order.

INSTRUCTIONS

1. The examples printed on the back of the first page of this form may be helpful in executing the Designation of Beneficiary.

2. All entries on the form except signatures should be typed or printed in ink (typewriting preferred). All designations of beneficiary or beneficiaries should be executed on the prescribed form of Designation of Beneficiary, Standard Form No. 1152, and must be signed and witnessed.

3. Complete the form in duplicate and file with the agency in which employed. A Designation of Beneficiary must be received by the employing agency prior to the death of the designating employee to be valid. The duplicate will be noted and returned to the employee as evidence that the original has been received and filed. It is suggested that the duplicate be filed with the employee's important papers.

4. Cancellation of a prior Designation of Beneficiary may be effected without the naming of a new beneficiary by executing a new Designation of Beneficiary, Standard Form No. 1152, and inserting in the space provided for name of beneficiary the words, "Cancel prior designations." The effect of this action will require payment to be made in the order of precedence stated above.

5. A designation will remain valid only as long as the employee remains continuously employed in the same agency. In case of separation and reemployment, or transfer to another agency, a new Designation of Beneficiary should be executed if the order of precedence established by the act is not acceptable. It is not necessary to file a new designation where the name or address of the employee or of beneficiary is changed.

6. A designation free of erasures or alterations should be filed in order to avoid a possible contest after death.

7. In the absence of the prescribed form, any designation, change, or cancellation of beneficiary witnessed and filed in accordance with the general requirements of these instructions shall be acceptable.

This Designation of Beneficiary Form is to be used solely for the disposition of unpaid compensation at death of a civilian employee and is not to be confused with Standard Form No. 2808 Designation of Beneficiary Civil Service Retirement System. The latter form distinguished by its yellow color is to be used only for the disposition of death benefits which may be due and payable under the Civil Service Retirement Act of May 29, 1930, as amended.

FORM 33

Form No. DJ-60
(Ed. 8-7-57)

DEPARTMENT OF JUSTICE

ADMINISTRATIVE EXPENSE CONTROL

"Salaries and Expenses, United States Attorneys and Marshals"

Date	Description	Item No.	Obligations	Disbursements	Balance
July 1	First Quarter Authorization	1			1,400.00
1	July Telephone Exp. (Est.)	2	225.00	✓	1,175.00
1	Postage	3	4.00	4.00	1,171.00
2	Typewriter Repair	4	12.25	✓	1,158.75
2	Western Union	5	1.20	✓	1,157.55
3	Office Supplies GSA	6	42.50		1,115.05
5	Postage	7	6.00	6.00	1,109.05
8	Pay Item No. 4	8	(.25)	12.00	1,109.30
8	Western Union	9	4.35	✓	1,104.95
9	Parcel Post	10	1.75	1.75	1,103.20
10	Employer's contributions payroll period 6/30 - 7/13/57	11	42.40	42.40	1,060.80
16	Western Union	12	4.21	✓	1,056.59
26	Employer's contributions payroll period 7/14 - 27/57	13	42.40	42.40	1,014.19
26	Postage	14	6.00	6.00	1,008.19
29	Freight	15	8.70		999.49
31	Employer's contributions on salaries earned but unpaid at July 31. (July 29, 30, 31)	16	12.72		986.77
			413.23	114.55	986.77
			114.55		
	Unpaid obligations for July Form USM-111		298.68		
Aug. 1	Totals brought forward		413.23	114.55	986.77
1	Aug. Telephone Exp. (Est.)	17	225.00		761.77
2	Pay Item No. 2	18	14.50	239.50	747.27
5	Pay Items 5, 9 & 12	19	-0-	9.76	747.27
7	Western Union	20	2.40		744.87
9	Employer's contributions payroll period 7/28 - 8/10/57	21	29.68	42.40	715.19

Note:

Item No. 8 Actual cost was $.25 less than amount obligated so minus $.25 is posted to obligation column.

Item No. 16 Three days salary earned but unpaid at end of July. Obligations established for Employer's Contributions (FICA, Insurance and Retirement) for three days.

Item No. 18 Actual cost of July telephone service was $14.50 more than the amount obligated so obligations are increased $14.50.

Control should be posted manually, exhibit is typed only for purpose of clarity.

Title 8

Note:

The Pages 197-198 were not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 35

Examples of Leave Computation

The new law has no retroactive effect on accumulations. Employees could have accumulated leave up to 60 days as of December 21, 1952. Unused 1952 leave balances which were required to be used by June 30, 1953, should be added to the employee's accumulated balance as of December 21, 1952. Absences since that date should be charged to 1953 annual leave accruals. For example:

	Days	Hours	Days	Hours
Accumulated 12/21/52	15	0	50	0
Leave to be used by 6/30/53	10	0	10	0
Amended accumulation 12/21/52	25	0	60	0
Accrued 12/21/52 through 1/2/54	20	6	20	6
(6-hour rate per pay period)	45	6	80	6
Used since 12/21/52	10	6	10	6
	35	0	70	0
Leave to be used by 12/31/53 (last work day of 1953 leave year) or forfeited	5	0	10	0
Maximum accumulation as of 1/3/54	30	0	60	0

The following examples reflect how terminal leave will be computed for persons who separate from the rolls in 1953 after August 31.

(a) Terminal leave computation of employee having less than 30 days accumulated as of December 21, 1952, as follows:

	Days
Accumulated 12/21/52	20
Leave to be used by 6/30/53	5
Amended accumulation 12/21/52	25
Accrued to date of separation 9/26/53	15
	40
Used to present date	5
	35
Lump sum payment limited to	30
Balance to be used prior to separation or forfeited	5

Employees in examples (*b*) and (*c*) below are entitled to terminal leave payment for accumulated annual leave from previous year, since both had in excess of 30 days as of 12/21/52.

	Days
(*b*) Accumulated 12/21/52	30
Leave to be used 6/30/53	5
Amended accumulation 12/21/52	35
Accrued to date of separation 9/26/53	15
	50
Used to present date	5
	45
Lump sum payment limited to	35
Balance to be used prior to separation or forfeited	10
(*c*) Accumulated 12/21/52	69
Accrued to date of separation 9/26/53	15
	84
Used to present date	10
	74
Lump sum payment limited to	69
Balance to be used prior to separation or forfeited	5

FORM 36

Form No. DJ-94a
(Ed. 11-12-49)
(Formerly Form 54 D.C.)
Form approved by
Comp. Gen., U.S.

ORIGINAL

DEPARTMENT OF JUSTICE

Bureau Vou. No. ....

United States Attorney - N. Calif.
(Bureau or Division)

Schedule No. ....

PAY VOUCHER FOR SPECIAL SERVICES

TO Richard Roe
(Name of payee)

Address 619 Monroe Road
Anytown, Anystate
(To which checks should be mailed)

	Period of service	Rate per Day	Amount Dollars	Amount Cents
For SERVICES rendered as Expert Witness	Days 4	25	100	00
from February 7, 19 62, to February 10, 19 62, inclusive.				
On account of U.S. vs. Single Construction Co. (State case or nature of business)				
REMARKS: Service was actually rendered on Saturday, February 10, 1962				

I CERTIFY that the above bill is correct and just and that payment has not been received.

(Sign original only)

Date 2/12/62 Payee /s/ Richard Roe

Amount claimed .... $ 100.00
Less differences, (See attached) .... $
Employee withholdings, (See reverse) .... $
Approved for payment .... $ 100.00

I CERTIFY that the foregoing account is correct and proper for payment.

Date February 14, 19 62 /s/ Luther Burbank
(Authorized Certifying Officer)

ACCOUNTING CLASSIFICATION (Appropriation Symbol must be shown; other classification optional)

U.S. GOVERNMENT PRINTING OFFICE 16—

FORM 37

APPLICATION ROSTER SHEET

Position_______________________________________

Name	Date appl. received	Priority group*	Considerations and other actions (show date)**

*Show "I", "II", "III".
**Use customary appointment and consideration Symbols—A NS, D, FR, ORU, etc

FORM 38

(Front)

MARSHAL'S COPY

UNITED STATES vs | WITNESS:

UNITED STATES DISTRICT COURT, | ADDRESS:

DISTRICT OF: | No.:

(An employee of the United States Attorney's or Commissioner's office will initial appropriate block for each day on which the witness attends)

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
MONTH	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Attendance checked above is correct. ______________________

CERTIFICATE OF U. S. ATTORNEY (U. S. COMMISSIONER)

I certify that the witness named above attended in the case or matter indicated and is entitled to the statutory allowances for attendance and travel. He (is) (is not) entitled to the subsistence allowance provided by law by reason of the distance involved from point of attendance to his residence.

In proceedings before United States Commissioner where more than four witnesses were used, the Commissioner further certifies that the approval and certificate of the U. S. Attorney were first obtained.

Date______________________19____ ______________________ (Signature of U. S. Attorney, Asst. U. S. Attorney or U. S. Commissioner)

WITNESS ATTENDANCE CERTIFICATE
FORM NO. USA-784 (REV. 6-1-61)
FORM APPROVED BY COMP. GEN., U. S.
JANUARY 17, 195[illegible]

(Back)

I CERTIFY that I attended as a witness on behalf of the United States in the case indicated to wit:

Date(s) of travel in coming to court______________________, 19____

Date(s) of attendance in court______________________, 19____

Date(s) of travel in returning home______________________, 19____

and that I traveled from__________ (Residence) __________to__________ (Place of holding court)

via__________ (Mode of transportation) __________for such attendance, a distance of__________miles (one way),

involving__________ round trip(s), that payment therefor has not been received, and that I am NOT an employee of the United States Government or detained witness.

Dated______________________, 19____ ______________________ (Signature of witness)

— FOR MARSHAL'S USE ONLY —

__________days at $4__________ $__________ Paid__________ (Date and D. O. Voucher Number)

__________days subsistence at $8 $__________

__________miles at 8 cents__________ $__________ Check No. (s)__________

Total $__________

Amt. Due (less advance) $__________ Deputy's initials__________

FORM 39

Standard Form 8
Revised May 1960
Department of Labor
Regulation 609.2

NOTICE TO FEDERAL EMPLOYEE ABOUT UNEMPLOYMENT COMPENSATION

This form has been given to you because (1) you have been separated from your job, or (2) you are expected to be in nonpay status for 7 calendar days or more, or (3) you have been transferred to another payroll office.

Federal workers have unemployment compensation rights similar to those of workers in private industry. If you become unemployed or are in nonpay status for 7 consecutive calendar days or more and you want to FILE A CLAIM, go to the nearest PUBLIC EMPLOYMENT OFFICE.

TAKE WITH YOU—

1. Your SOCIAL SECURITY ACCOUNT NUMBER CARD. (If you do not have a Social Security card, apply for one, but you do not need to delay filing your claim pending its receipt.)
2. The OFFICIAL NOTICE of your most recent SEPARATION or of your present NONPAY status (Standard Form 50, Payroll Change Slip SF–1126 or similar document), if you have received it.
3. THIS FORM, and all similar forms which you have received. The office where you file your claim will obtain information needed for your claim from

(Federal agency will insert in the box above name and address of office where your payroll records are maintained.)

KEEP THIS FORM with your Standard Form 50 and other personnel records. It is important to have it if you file a claim for unemployment compensation.

8-100

FORM 39 (back)

1. Who will pay unemployment benefits?

If you are eligible, you will be paid by a State employment security agency under the provisions of its unemployment compensation law. The amount of your weekly benefits and the period for which benefits will be paid will generally be determined by the law of the State in which you had your last *official station*. However, if your last official station was outside the United States, you will not be eligible until you return to the "States." Your benefit rights then will be determined under the law of your State of your residence.

These benefits are paid from funds furnished by the United States Government. You did not pay a payroll tax to provide for your unemployment insurance.

2. Under what conditions will I be eligible?

All State laws require that:

(*a*) You must be unemployed, able to work, and available for any suitable work;

(*b*) You must file a claim and must *register for* work at a local public employment office and must continue to report to that office as directed; and

(*c*) You must have had the employment or wages in a base period as specified in the State law.

All State laws will disqualify you for such reasons as the following:

(*a*) Quitting your job voluntarily without good cause or being discharged for misconduct connected with your work; or

(*b*) Refusing an offer of a suitable job without good cause.

The Federal law further provides that you will not be eligible for benefits until the period covered by your lump-sum payment for terminal annual leave has expired.

3. Do I have the right of appeal?

Yes. If a determination is made that you are ineligible for or are disqualified from benefits, you have the right to appeal provided in the applicable State law, but the Federal law provides that determinations of Federal service and wages and reasons for termination of Federal service given by the Federal agency shall be conclusive. If you believe that the information reported by your Federal agency is incorrect, you can ask—through the local employment office where you filed your claim—for a review by the Federal agency.

4. Are there any penalties?

Yes. If you willfully make a fraudulent claim, you are subject to a fine or imprisonment, or both. If you made a mistake in giving information when you filed your claim, notify the local employment office as soon as you discover the mistake, in order to avoid penalty.

U. S. GOVERNMENT PRINTING OFFICE : 1960—O-[illegible]

FORM 40

STANDARD FORM 53. JUNE 1963 U.S. CIVIL SERVICE COMMISSION FPM SUPPLEMENT 870-1 53-106	WAIVER OF LIFE INSURANCE COVERAGE FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ACT OF 1954, AS AMENDED	FOR AGENCY USE ONLY: DATE WAIVER RECEIVED	FOR AGENCY USE ONLY: DATE WAIVER EFFECTIVE
1. NAME (*Last*) (*First*) (*Middle*)		2. DATE OF BIRTH (*Month*) (*Day*) (*Year*)	
3. DEPARTMENT OR AGENCY	4. LOCATION	5. DATE OF THIS WAIVER (*Month*) (*Day*) (*Year*)	

I desire not to be insured under the group life insurance plan in accordance with the Federal Employees' Group Life Insurance Act of 1954, as amended, and I hereby waive any benefits provided by the plan.

I understand that, under present regulations, I will not be eligible to participate in the plan until at least 1 year has elapsed from the effective date of this waiver and unless at the time I make written request to participate I am under age 50 and present satisfactory medical evidence of insurability.

I understand also that if at any time in the future I desire to participate in the insurance plan, my eligibility to do so will be subject to regulations in effect at that time.

Signature of EMPLOYEE—DO NOT PRINT

Signature of WITNESS—DO NOT PRINT | Address of WITNESS

Signature of WITNESS—DO NOT PRINT | Address of WITNESS

INSTRUCTIONS TO AGENCY

1. A new employee who desires not to be insured must complete and file this form with the employing agency on or before his first day in a pay status. A waiver thus filed is effective on the employee's first day in a pay status.
2. An insured employee who desires to become uninsured may do so by completing and filing this form with his employing agency. When filed by an insured employee, the waiver becomes effective at midnight of the last day of the pay period in which it is received by the agency.
3. Whenever an employee files a waiver, this fact must be noted on his individual pay record. After payroll actions have been completed, the waiver must be filed in the employee's Official Personnel Folder (or its equivalent).
4. This form, properly executed, is authority to relieve an employing office from salary withholdings for insurance purposes.

☆ U.S. GOVERNMENT PRINTING OFFICE : [illegible]

FORM 41 (face)

Standard Form No. 54
July 1962
U.S. Civil Service Commission
FPM Supplement 990-1
64-105

DESIGNATION OF BENEFICIARY
FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ACT OF 1954

IMPORTANT
Read instructions on back of duplicate before filling in this form

INFORMATION CONCERNING THE INSURED:

NAME (Last) (First) (Middle) | DATE OF BIRTH (Month, day, year)

PLACE AN "X" IN THE APPROPRIATE BOX BELOW TO SHOW WHETHER YOU ARE:

☐ AN EMPLOYEE ☐ RETIRED OR AN APPLICANT FOR RETIREMENT ☐ RECEIVING FEDERAL EMPLOYEES' COMPENSATION BENEFITS OR AN APPLICANT FOR SUCH BENEFITS

IF YOU ARE RETIRED OR RECEIVING FEDERAL EMPLOYEES' COMPENSATION GIVE YOUR "CSA," "CSI," or "X" NUMBER

(CSA or CSI or X number)

DEPARTMENT OR AGENCY IN WHICH LAST EMPLOYED (If retired, former department or agency):

(Department or agency) (Bureau) (Division) (Location—City and State)

I, the individual identified above, canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Act heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any amount of GROUP LIFE INSURANCE and GROUP ACCIDENTAL DEATH INSURANCE due and payable at my death. I understand that this Designation of Beneficiary will remain in full force and effect, with respect to any amount payable, unless or until canceled by me in writing, or until such time as it is automatically canceled (see regulation "f" on reverse side of duplicate copy).

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share of any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any Designation of Beneficiary at any time without knowledge or consent of the beneficiary.

(Date of execution—month, day, year) (Signature of insured)

WITNESSES TO SIGNATURE (*A witness is ineligible to receive payment as a beneficiary*):

(Signature of witness) (Number and street) (City, State, and Zip Code)

(Signature of witness) (Number and street) (City, State, and Zip Code)

PRINT OR TYPE NAME AND ADDRESS OF INSURED | THIS SPACE RESERVED FOR RECEIVING AGENCY

(Indicate date and by whom received)

SEE REVERSE SIDE OF DUPLICATE COPY FOR INSTRUCTIONS ON WHERE TO FILE THESE FORMS.
DO NOT FILE WITH THE OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE.

16—70610-4

FORM 41 (back)

IMPORTANT.—The filing of this form will completely cancel any Designation of Beneficiary under the Federal Employee's Group Life Insurance Act you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any group life and accidental death insurance payable under that act at your death.

EXAMPLES OF DESIGNATIONS

How To Designate One Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Mary E. Brown*	214 Central Avenue, Muncie, Ind.	Niece	All

How To Designate More Than One Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Alice M. Long	509 Canal Street, Red Bank, N. J.	Aunt	** One-fourth
Joseph P. Brady	360 Williams Street, Red Bank, N. J.	Nephew	One-fourth
Catherine L. Rowe	792 Broadway, Whiting, Ind.	Mother	One-half

How To Designate a Contingent Beneficiary

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
John M. Parrish, if living	810 West 180th Street, New York, N. Y.	Father	All
Otherwise to: Susan A. Parrish	810 West 180th Street, New York, N. Y.	Sister	All

How To Cancel a Designation of Beneficiary so That Amount Due Will Be Payable as Provided in the Law

Type or print first name, middle initial, and last name of each beneficiary	Type or print address of each beneficiary	Relationship	Share to be paid to each beneficiary
Cancel prior designations			

*Do not write name as M. E. Brown or as Mrs. John H. Brown.
**Be sure that the shares to be paid to the several beneficiaries add up to 100 percent.

16—70610-4

FORM 41 (back of duplicate)

INSTRUCTIONS

1. The examples printed on the back of the first page of this form may be helpful in executing the Designation of Beneficiary.

2. All entries on the form except signatures should be typed or printed in ink (typewriting preferred). All designations of beneficiary or beneficiaries should be executed on the prescribed Designation of Beneficiary, Standard Form 54, and must be signed by the insured and witnessed.

3. Complete the form in duplicate. If insured as an employee, file the form with the agency in which employed. If insured as a retired employee or because receiving Federal employees' compensation, file the form with the U. S. Civil Service Commission, Washington, D. C., 20415. If an application for retirement or compensation is pending, file the form with the agency in which employed if still an insured employee or with the U. S. Civil Service Commission if no longer an insured employee. A Designation of Beneficiary must be received by the proper agency prior to the death of the insured to be valid. The duplicate will be noted and returned as evidence that the original has been received and filed. It is suggested that the duplicate be kept with the Certificate of Group Insurance.

4. Cancellation of a prior Designation of Beneficiary may be effected without the naming of a new beneficiary by executing a new Designation of Beneficiary, Standard Form 54, and inserting in the space provided for name of beneficiary the words, "Cancel prior designations." The effect of this action will require payment to be made in accordance with the order of precedence under the Federal Employees' Group Life Insurance Act.

5. It is not necessary to file a new Designation of Beneficiary where the name or address of the insured or the beneficiary is changed.

6. A Designation of Beneficiary must be free of erasures or alterations.

7. In the absence of the prescribed form, any designation, change, or cancellation of beneficiary witnessed and filed in accordance with the general requirements of these instructions shall be acceptable.

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*This Designation of Beneficiary Form is to be used solely for the disposition of proceeds of insurance under the Federal Employees' Group Life Insurance Act and is not to be confused with Standard Form 2808, Designation of Beneficiary, Civil Service Retirement System, or Standard Form 1152, Designation of Beneficiary, Unpaid Compensation of Deceased Civilian Employees.

REGULATIONS

(*a*) The Designation of Beneficiary shall be in writing, signed and witnessed, and received in the employing office (or, in the case of (1) a retired employee and (2) an employee, whose insurance is continued while he is receiving benefits under the Federal Employees' Compensation Act because of disease or injury to himself and who is held by the Department of Labor to be unable to return to duty, in the Civil Service Commission) prior to the death of the designator.

(*b*) No change or cancellation of beneficiary in a last will or testament, or in any other document not witnessed and filed as required by these regulations, shall have any force or effect.

(*c*) A witness to a Designation of Beneficiary shall be ineligible to receive payment as a beneficiary.

(*d*) Any person, firm, corporation, or legal entity (except an agency of the Federal or District of Columbia Governments) may be named as beneficiary.

(*e*) A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary, and this right cannot be waived or restricted.

(*f*) A Designation of Beneficiary is automatically canceled (1) on the day the employee transfers to another agency, or (2) 31 days after the employee ceases to be insured.

16—70610-4 U. S. GOVERNMENT PRINTING OFFICE

Form 41b (front)

STANDARD FORM 55
APRIL 1964
U.S. CIVIL SERVICE COMMISSION
FPM SUPPLEMENT 870-1 55-105

NOTICE OF CONVERSION PRIVILEGE
Federal Employees' Group Life Insurance Act

You are entitled to convert to an individual policy unless, within 3 calendar days after the date your insurance terminates, you return to Government service in the same or another position in which you are eligible to reacquire Federal Employees' Group Life Insurance. Any individual policy purchased under a conversion privilege is a private business transaction between you and the eligible insurance company you select. Here are the important things you should know about your conversion privilege:

- YOU MAY PURCHASE AN INDIVIDUAL POLICY IN AN AMOUNT EQUAL TO OR LESS THAN YOUR GROUP LIFE INSURANCE.
- NO MEDICAL EXAMINATION IS REQUIRED.
- YOU MUST PAY THE LIFE INSURANCE PREMIUM APPLICABLE TO THE TYPE OF POLICY YOU SELECT AND YOUR AGE AND CLASS OF RISK. See the other side of this form for information on types and costs of individual policies.
- THE GOVERNMENT WILL NOT PAY ANY PART OF THE PREMIUM COST OF YOUR INDIVIDUAL POLICY.
- YOUR INDIVIDUAL POLICY MAY BE ISSUED BY ANY INSURANCE COMPANY YOU SELECT FROM THE LIST OF ELIGIBLE COMPANIES WHICH YOU WILL RECEIVE IF YOU APPLY FOR CONVERSION.
- YOUR INDIVIDUAL POLICY MAY BE IN ANY FORM CUSTOMARILY ISSUED BY THE INSURANCE COMPANY, EXCEPT TERM INSURANCE, BUT WITHOUT DISABILITY OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS.

HOW TO CONVERT

If you wish to exercise your privilege of converting to an individual policy, you must:

1. Ask the agency identified below to give you a completed Agency Certification of Insurance Status, and

2. Follow the instructions printed on the Agency Certification of Insurance Status and mail it to the Office of Federal Employees' Group Life Insurance, 2 East 24th St., New York, N.Y., 10010. That office will promptly mail to you detailed information on how to apply for conversion, together with a list of insurance companies eligible to convert your insurance.

IMPORTANT

THE TIME IN WHICH AN EMPLOYEE MAY CONVERT IS LIMITED. THE COMPLETED "AGENCY CERTIFICATION OF INSURANCE STATUS" (NOT THIS FORM) MUST BE MAILED TO THE OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE WITHIN 31 DAYS AFTER YOUR GROUP INSURANCE TERMINATES, OR WITHIN 15 DAYS AFTER THE DATE OF THIS NOTICE, WHICHEVER BASIS GIVES YOU THE MOST TIME.

UNDER CERTAIN CONDITIONS, LIFE INSURANCE IS PAYABLE IF DEATH OCCURS WITHIN 31 DAYS AFTER AN EMPLOYEE'S GROUP INSURANCE TERMINATES, REGARDLESS OF WHETHER HE HAS APPLIED FOR CONVERSION. IF DEATH OCCURS WITHIN THIS PERIOD FURTHER INFORMATION CONCERNING POSSIBLE BENEFITS MAY BE OBTAINED FROM THE AGENCY NAMED BELOW.

DATE OF THIS NOTICE

NAME AND MAILING ADDRESS OF AGENCY

INSTRUCTIONS TO EMPLOYING AGENCY

1. Fill in the name and address of the office which issues this notice (overprint or stamp if desired).
2. Fill in the date this notice is issued, and note this date in your records for possible future reference.
3. Give this notice, as required, to every employee on the date his insurance terminates (except by waiver).

(SEE OTHER SIDE)

Form 41b (back)

TYPES OF POLICIES

The type of individual policy you select should be determined by the purpose which the policy is to serve, taking into account your other financial plans and resources. There are three basic forms of permanent policies, however, and other life insurance policies are primarily combinations or modifications of these three. The three basic policies are:

- An *Ordinary Life* policy, also known as a Whole Life policy or a Straight Life policy, provides lifetime protection in return for premium payments throughout your entire life. The policy builds a CASH VALUE after one, two, or three years. You may withdraw this cash if you decide to stop paying premiums. Also, you may borrow upon it at any time for any purpose.

- A *Limited Payment Life* policy differs from Ordinary Life in three ways. First, while it also provides lifetime protection, premiums are paid over a specific number of years—usually 10, 20, or 30, or until a certain age, such as 65. Secondly, the company must charge a higher annual premium during these years. Finally, because premiums are higher, the policy's CASH VALUE increases faster.

- *Endowment* policies emphasize savings. They pay you a sum of money at a future date named in the policy—such as at the end of 20 years or at age 65. If you do not live until that date, this sum of money is paid upon your death to a beneficiary named by you. Both premiums and CASH VALUE are higher than for the other types of policies.

COST OF INDIVIDUAL POLICY

Life insurance policies are issued on a participating or non-participating basis.

Premiums for participating policies are higher than those charged for non-participating policies. The part of a participating premium which is found not to be needed to furnish protection is refunded in the form of an annual dividend to the policyholder. The first dividend is usually available after premiums have been paid for one, two, or three years. To obtain the net cost of a participating policy, you should deduct these yearly dividends from the premiums.

For non-participating policies, premiums are as close as possible to what the company estimates will be needed to meet the actual cost of providing insurance protection. The premium measures the guaranteed cost to the policyholder who purchases a non-participating policy. No dividends are paid under these policies.

The following are approximate premium rates on the participating basis for Ordinary Life, the Twenty-payment Life and Twenty-year Endowment policies. The rates are shown for ages 20 to 65 at five year age intervals. Premium rates for non-participating policies are somewhat lower and no dividends will be paid under those policies. *The rates shown below are examples only and are not the rates for any one company.*

ANNUAL PREMIUM RATES PER $1,000 OF INSURANCE

AGE OF INSURED AT ISSUANCE OF POLICY	ORDINARY LIFE	20 PAYMENT LIFE	20-YEAR ENDOWMENT	AGE OF INSURED AT ISSUANCE OF POLICY	ORDINARY LIFE	20 PAYMENT LIFE	20-YEAR ENDOWMENT
PARTICIPATING INSURANCE (ANY DIVIDENDS PAID WILL REDUCE THESE COSTS)							
20	$18.00	$30.00	$49.00	45	$39.00	$50.00	$57.00
25	$21.00	$33.00	$50.00	50	$47.00	$56.00	$62.00
30	$24.00	$36.00	$51.00	55	$58.00	$65.00	$69.00
35	$28.00	$40.00	$52.00	60	$73.00	$78.00	$79.00
40	$33.00	$44.00	$54.00	65	$94.00	$95.00	$96.00

* U.S. GOVERNMENT PRINTING OFFICE [illegible]

Form 41c (front)

STANDARD FORM 56
REVISED JULY 1963
U.S. CIVIL SERVICE COMMISSION
F.P.M. SUPPLEMENT 870-1 56-105

AGENCY CERTIFICATION OF INSURANCE STATUS
Federal Employees' Group Life Insurance Act

1. FULL NAME OF EMPLOYEE (Last) (First) (Middle)

2. DATE OF BIRTH (MONTH, DAY, YEAR)

3. CHECK THE REASON FOR TERMINATING INSURANCE

(a). ☐ SEPARATED
(b). ☐ RETIRED
(c). ☐ DIED — WAS EMPLOYEE AT TIME OF DEATH AN APPLICANT FOR CIVIL SERVICE RETIREMENT? ☐ YES ☐ NO
(d). ☐ 12 MONTHS NON-PAY STATUS
(e). ☐ OTHER (Specify)

4. CHECK APPROPRIATE BOX CONCERNING S. F. 54, DESIGNATION OF BENEFICIARY

(a). ☐ CURRENT S. F. 54 ATTACHED
(b). ☐ A CURRENT S. F. 54 IS NOT ON FILE WITH THIS AGENCY
(c). ☐ A CURRENT S. F. 54 IS ON FILE IN THE EMPLOYEE'S OFFICIAL PERSONNEL FOLDER (OR EQUIVALENT)

NOTE: IF EMPLOYEE (A) DIED OR (B) IS RETIRING OR RECEIVING FEDERAL EMPLOYEES' COMPENSATION UNDER CONDITIONS ENTITLING HIM TO RETAIN FREE LIFE INSURANCE, ATTACH CURRENT S. F. 54, IF ANY, TO ORIGINAL S. F. 56 AND CHECK BOX 4 (a) ON ORIGINAL AND ALL COPIES OF S. F. 56; IF NO CURRENT S. F. 54 IS ON FILE, CHECK BOX 4 (b). IN ALL OTHER CASES, SHOW WHETHER OR NOT CURRENT S. F. 54 IS ON FILE BY CHECKING BOX 4 (b) OR (c). A CURRENT S. F. 54 IS ONE THAT HAS NOT BEEN CANCELED BY EMPLOYEE OR AUTOMATICALLY BY TRANSFER OR PRIOR TERMINATION OF INSURANCE.

5. DATE OF EVENT CHECKED IN ITEM 3 (MONTH, DAY, YEAR)

6. ANNUAL COMPENSATION RATE - NOT AMOUNT OF INSURANCE - (CONVERT DAILY, HOURLY, PIECEWORK, ETC. RATE TO ANNUAL RATE) ON DATE IN ITEM 5.
$________ PER ANNUM

7. DATE OF NOTICE OF CONVERSION PRIVILEGE (SF 55) TO EMPLOYEE (MONTH, DAY, YEAR)

8. I CERTIFY THAT THE ABOVE INFORMATION HAS BEEN OBTAINED FROM, AND CORRECTLY REFLECTS OFFICIAL RECORDS, AND THAT THE EMPLOYEE NAMED WAS COVERED BY FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ON THE DATE SHOWN IN ITEM 5. (SIGN ORIGINAL ONLY)

(Personal signature of authorized agency official) (Date)

(Type name of authorized agency official) (Title)

(Name of agency) (Mailing address of agency)

IMPORTANT INFORMATION FOR EMPLOYEE

NOTICE TO RETIRING EMPLOYEE

As a retired employee, your group life insurance (not accidental death and dismemberment) will be continued without cost to you, provided:

- You do not convert to an individual policy of life insurance; and
- You retire with 12 or more years' creditable service of which at least 5 years are civilian service, or on account of disability; and
- You retire on an immediate annuity, that is, one that begins to accrue not later than 1 month after the date your insurance as an employee would otherwise terminate.

Your group life insurance as a retired employee, which is based on your salary (not your annuity), will be reduced by 2% each month beginning at age 65 or the date your insurance as an employee would otherwise terminate, whichever is later. The maximum reduction is 75%. The date your insurance as an employee terminates is shown in item 5 above.

If you are eligible to continue your group life insurance as a retiring employee, your employing agency has been instructed to attach the ORIGINAL of this form to your application for retirement unless you prefer to convert to an individual policy.

If you receive the ORIGINAL copy of this Certification after you file your application for retirement, and you do not want to convert to an individual policy, forward the ORIGINAL as soon as possible to the agency or office which administers your retirement system.

Keep the DUPLICATE copy for yourself. You will be notified by the Civil Service Commission of your insurance rights.

DEATH WITHIN 31 DAYS

Under certain conditions life insurance is payable if death occurs within 31 days after an employee's group insurance terminates, even though he had not applied for conversion. If death occurs within this period, further information concerning possible benefits should be obtained from the agency named in item 8 above.

SEE OTHER SIDE

FOR ADDITIONAL IMPORTANT INFORMATION AND INSTRUCTIONS ABOUT CONVERSION TO AN INDIVIDUAL POLICY AND CONTINUATION OF INSURANCE WHILE RECEIVING FEDERAL EMPLOYEES' COMPENSATION

PART 1 — ORIGINAL

742-196—64——5

Form 41c (back)

IMPORTANT INFORMATION FOR EMPLOYEE
(continued from other side)

CONVERSION TO AN INDIVIDUAL POLICY

IF YOU ARE RETIRING OR ARE RECEIVING FEDERAL EMPLOYEES' COMPENSATION BENEFITS YOU MAY BE ENTITLED TO CONTINUE YOUR INSURANCE WITHOUT COST TO YOURSELF IF YOU DO NOT CONVERT TO AN INDIVIDUAL POLICY. PLEASE SEE "NOTICE TO RETIRING EMPLOYEE" ON THE OTHER SIDE OR "COVERAGE WHILE IN RECEIPT OF FEDERAL EMPLOYEES' COMPENSATION" BELOW FOR DETAILS.

You are eligible to convert to an individual policy unless, within 3 calendar days after the date shown in Item 5 on the other side of this sheet, you return to Government service in the same or another position in which you are eligible to reacquire Federal Employees' Group Life Insurance. You have no right to convert to an individual policy and you cannot properly use this Certification for conversion purposes if you are eligible to reacquire group life insurance within the period specified in the preceding sentence.

READ THE IMPORTANT INFORMATION ABOUT CONVERSION ON THE BACK OF THE DUPLICATE COPY OF THIS CERTIFICATION. Then, if you are eligible to convert to an individual policy and desire to exercise your conversion privilege, complete this Certification by signing your name, typing or printing your address and the date in the Eligibility Statement below. Send the original of this form to the OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE, 25 EAST 24TH STREET, NEW YORK 10, N. Y. The envelope containing this form must be postmarked within 31 days of the date your group insurance terminated (see item 5 on the other side of this sheet) or within 15 days of the date of conversion notice (see item 7), whichever basis gives you the most time. Information on how to apply for conversion will be mailed to you promptly.

ELIGIBILITY STATEMENT

I have read all the above information and am eligible to convert to an individual policy. Please send additional information.

(Your personal signature)	(Please type or print your address — number, street, city, zone, state)	(Date)

COVERAGE WHILE IN RECEIPT OF FEDERAL EMPLOYEES' COMPENSATION BECAUSE OF JOB INCURRED DISEASE OR INJURY TO YOURSELF

If you do not convert to an individual policy, your group life insurance (not accidental death or dismemberment) may continue without cost to you while you are in receipt of benefits under the Federal Employees' Compensation Act and are held by the Department of Labor to be unable to return to duty.

You may apply to continue your insurance coverage by signing your name and giving your address and compensation claim number in the spaces provided in this box and mailing this form to the U. S. CIVIL SERVICE COMMISSION, BUREAU OF RETIREMENT AND INSURANCE, WASHINGTON 25, D. C. When your compensation benefits cease or you are held to be able to return to duty your insurance will be terminated without the right to convert to an individual policy. If you then return to employment in which you are not excluded from insurance coverage, you will again be insured as an employee. If you are eligible for continued group life insurance as a retired employee, you may retain insurance coverage on that basis, but subject to reduction as explained in the "Notice to Retiring Employee" on the other side of this sheet.

Upon receipt of this form the Commission will verify your compensation status and notify you of your insurance rights.

(Your personal signature)	(Compensation claim number)

(Please type or print your address — number, street, city, zone, state)

Form 41c (back)

IMPORTANT INFORMATION ON CONVERSION TO AN INDIVIDUAL POLICY

Any individual policy purchased under a conversion privilege is a private business transaction between you and the eligible insurance company you select. Here are some important things you should know:

- You may purchase an individual policy in an amount equal to or less than your group life insurance.
- You must pay the life insurance premium applicable to the type of policy you select and your age and class of risk.
- The Government will not pay any part of the premium cost of your individual policy.
- Your individual policy may be issued by any eligible insurance company that has agreed to issue such policies.
- Your individual policy may be in any form customarily issued by the insurance company, except term insurance, but without disability or accidental death and dismemberment benefits.
- No medical examination is required.

<u>TYPES OF POLICIES.</u> — The type of individual policy you select should be determined by the purpose which the policy is to serve, taking into account your other financial plans and resources. There are three basic forms of permanent policies, however, and other life insurance policies are primarily combinations or modifications of these three. The three basic policies are described below:

- An <u>Ordinary Life</u> policy, also known as a Whole Life policy or a Straight Life policy, provides life-time protection in return for premium payments throughout your entire life. The policy builds a CASH VALUE after one, two, or three years. You may withdraw this cash if you decide to stop paying premiums. Also, you may borrow upon it at any time for any purpose.
- A <u>Limited Payment Life</u> policy differs from Ordinary Life in three ways. First, while it also provides lifetime protection, premiums are paid over a specific number of years — usually 10, 20, or 30, or until a certain age, such as 65. Secondly, the company must charge a higher annual premium during these years. Finally, because premiums are higher, the policy's CASH VALUE increases faster.
- <u>Endowment</u> policies emphasize savings. They pay you a sum of money at a future date named in the policy — such as at the end of 20 years or at age 65. If you do not live until that date, this sum of money is paid upon your death to a beneficiary named by you. Both premiums and CASH VALUE are higher than for the other types of policies.

<u>COST OF INDIVIDUAL POLICY.</u> — Life insurance policies are issued on a participating or non-participating basis.

Premiums for participating policies are higher than those charged for non-participating policies. The part of a participating premium which is found not to be needed to furnish protection is refunded in the form of an annual dividend to the policyholder. The first dividend is usually available after premiums have been paid for one, two, or three years. To obtain the net cost of a participating policy, you should deduct these yearly dividends from the premiums.

For non-participating policies, premiums are as close as possible to what the company estimates will be needed to meet the actual cost of providing insurance protection. The premium measures the guaranteed cost to the policyholder who purchases a non-participating policy. No dividends are paid under these policies.

The following are approximate premium rates on the participating basis for Ordinary Life, the Twenty-payment Life and Twenty-year Endowment policies. The rates are shown for ages 20 to 65 at five year age intervals. Premium rates for non-participating policies are somewhat lower and no dividends will be paid under those policies. <u>The rates shown below are examples only and are not the rates for any one company.</u>

ANNUAL PREMIUM RATES PER $1,000 OF INSURANCE

AGE OF INSURED AT ISSUANCE OF POLICY	ORDINARY LIFE	20-PAYMENT LIFE	20-YEAR ENDOWMENT	AGE OF INSURED AT ISSUANCE OF POLICY	ORDINARY LIFE	20-PAYMENT LIFE	20-YEAR ENDOWMENT
		PARTICIPATING INSURANCE (ANY DIVIDENDS PAID WILL REDUCE THESE COSTS)					
20	$ 18.00	$ 30.00	$ 49.00	45	$ 39.00	$ 50.00	$ 57.00
25	21.00	33.00	50.00	50	47.00	56.00	62.00
30	24.00	36.00	51.00	55	58.00	65.00	69.00
35	28.00	40.00	52.00	60	73.00	78.00	79.00
40	33.00	44.00	54.00	65	94.00	95.00	96.00

<u>HOW TO CONVERT.</u> — To convert to an individual policy, follow the instructions on the back of Part I - The Original copy of this Certification.

Form 41c (back)

INSTRUCTIONS TO EMPLOYING AGENCY

COMPLETION OF CERTIFICATION

1. This Certification must be completed in triplicate whenever an employee's insurance terminates for:
   a. Death.
   b. Retirement on an immediate annuity with 12 or more years' creditable service, of which at least 5 years are civilian service, or on account of disability. (An immediate annuity is one which begins to accrue not later than 1 month after the date the insurance would normally cease.) In a disability retirement case, do not complete S.F. 56 until a finding of disability has been officially made and the employee's separation is in order.
   c. Completion of 12 months in a non-pay status or separation, and the employee is receiving benefits under the Federal Employees' Compensation Act.
   d. Any other reason, if the employee desires to convert his group life insurance, except under the following circumstances:
      (1) Employee waived on S.F. 53;
      (2) If it is known that, within 3 calendar days after the date the insurance terminated, the employee will return to Government service in the same or another position in which he will be eligible to reacquire Federal Employees' Group Life Insurance;
      (3) More than 75 days have elapsed from the date insurance terminated unless specific request is made therefor by the Civil Service Commission or the Office of Federal Employees' Group Life Insurance.
2. If insurance terminated on account of death, indicate whether the employee had filed an Application for Retirement (S.F.2801) with the Civil Service Commission.
3. In item 7, give date of Notice of Conversion Privilege (S.F. 55), except that if this form (S.F. 56) is issued in lieu of S.F. 55, give current date. In case of death, leave this item blank.

DISPOSITION OF CERTIFICATION

1. Death of employee—
   a. Send duplicate copy of Certification immediately to the Office of Federal Employees' Group Life Insurance.
   b. Keep the original (preferably in the Official Personnel Folder or its equivalent) for attachment to a claim for death benefits (Form FE-6) when received.
   c. If no claim is received, send the original Certification, upon request, to the Office of Federal Employees' Group Life Insurance.
   d. If the deceased employee has a current designation of beneficiary on file, the designation (S.F. 54) must be attached to the original Certification when it is sent to the Office of Federal Employees' Group Life Insurance.
2. Retirement of employee—
   a. If the employee is applying for an immediate annuity (with 12 or more years' creditable service, of which at least 5 years are civilian service or for disability), attach the original Certification and current designation of beneficiary, (S.F. 54), if any, to the application for retirement and give duplicate copy of Certification to the employee. (NOTE: In a disability retirement case where the application has already been sent to the Civil Service Commission, attach the original S.F. 56 (and S.F. 54, if any,) to the "FINAL" Individual Retirement Record (S.F. 2806).)
   b. If the employee prefers to convert his group insurance to an individual policy, give him the original and duplicate copy of the Certification. Retain S.F. 54, if any.
3. Employee in receipt of compensation benefits—
   a. If the employee is receiving benefits under the FEDERAL EMPLOYEES' COMPENSATION ACT on account of a job incurred disease or injury to himself, have him complete appropriate box on reverse side of the original Certification. Send original Certification and current designation of beneficiary (S.F. 54), if any, to the U. S. CIVIL SERVICE COMMISSION, BUREAU OF RETIREMENT AND INSURANCE, WASHINGTON, D.C. 20415 and give duplicate copy of Certification to the employee.
   b. If the employee prefers to convert his group insurance to an individual policy, give him the original and duplicate copy of the Certification. Retain S.F. 54, if any.
4. All other cases—

   Upon request, give the employee the original and duplicate copy of the Certification or mail them to him.
5. In all cases—

   Retain file copy of the Certification in the employee's Official Personnel Folder or its equivalent.

PROMPT CERTIFICATION REQUIRED

The time in which an employee may convert his group life insurance to an individual policy is limited. This Certification must be completed and delivered or mailed to him promptly.

Form 41d (front)

Form FE-6 (7-61) OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE 25 East 24th Street New York 10, New York	**CLAIM FOR DEATH BENEFITS** FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ACT OF 1954, AS AMENDED	READ INSTRUCTIONS BEFORE FILLING OUT THIS FORM.

PART A. GENERAL INFORMATION CONCERNING THE DECEASED

1. FULL NAME OF THE DECEASED (*Last*) (*First*) (*Middle*) MR. MRS. MISS	2. DATE OF BIRTH *Month* *Day* *Year*	3. DATE OF DEATH *Month* *Day* *Year*
4. DEPARTMENT OR AGENCY IN WHICH LAST EMPLOYED, INCLUDING BUREAU OR DIVISION	5. LOCATION OF LAST EMPLOYMENT (*City and State*) 6. DOMICILE—(*Legal Residence at Time of Death—City and State*)	7. DATE OF FINAL SEPARATION (*If Different From Date of Death*) *Month* *Day* *Year*

8. WAS DECEASED RETIRED AND RECEIVING ANNUITY UNDER ANY FEDERAL CIVILIAN RETIREMENT SYSTEM, INCLUDING OLD-AGE AND SURVIVORS INSURANCE (SOCIAL SECURITY)? ☐ YES ☐ NO GIVE CLAIM NUMBER, IF KNOWN______	9. (a) WAS DECEASED ON ACTIVE DUTY IN THE MILITARY FORCES OF THE U. S. AT TIME OF DEATH? ☐ YES ☐ NO 9. (b) IF "YES," STATE BELOW			
	BRANCH OF SERVICE	SERIAL NO.	GRADE OR RANK	ORGANIZATION AT TIME OF DEATH (*Regiment, Co., etc.*)

IF THE DECEASED NAMED YOU AS BENEFICIARY ON STANDARD FORM 54 attach a receipted copy of the Designation of Beneficiary (Standard Form 54) to this claim, give your age and relationship in the box to the right, and complete Part F. on the other side. IF A RECEIPTED COPY OF STANDARD FORM 54 IS NOT ATTACHED, YOU MUST COMPLETE ALL PARTS OF THIS CLAIM FORM.	Your Age Relationship to Deceased

PART B. PERSONAL INFORMATION CONCERNING THE DECEASED

1. HOW MANY TIMES WAS DECEASED MARRIED?	3. GIVE NAME OF EACH SPOUSE (*Including all former marriages*)	4. HOW WAS MARRIAGE TERMINATED? (*check one in each case*)	5. DATE MARRIAGE WAS TERMINATED
		☐ DEATH ☐ DIVORCE	
		☐ DEATH ☐ DIVORCE	
2. WAS THE DECEASED SURVIVED BY ANY CHILDREN? ☐ YES ☐ NO		☐ DEATH ☐ DIVORCE	

PART C. INFORMATION CONCERNING THE CLAIMANT

1. YOUR NAME (*Last*) (*First*) (*Middle*) MR. MRS. MISS	2. YOUR RELATIONSHIP TO THE DECEASED	3. YOUR DATE OF BIRTH *Month* *Day* *Year*
FILL IN BLANKS 4 THROUGH 14 IF YOU ARE THE WIDOW OR WIDOWER OF THE DECEASED.		
4. DATE OF MARRIAGE *Month* *Day* *Year*	5. PLACE OF MARRIAGE (*City and State*)	6. MARRIAGE WAS PERFORMED BY ☐ CLERGYMAN OR JUSTICE OF PEACE ☐ OTHER (*Specify*)

7. WERE YOU LIVING WITH DECEASED AT TIME OF DEATH? ☐ YES ☐ NO	8. IF NOT LIVING WITH DECEASED AT DEATH, WAS THERE A DIVORCE? ☐ YES ☐ NO
9. IF YOU WERE DIVORCED FROM DECEASED, GIVE DATE AND PLACE OF DIVORCE MONTH | DAY | YEAR | CITY | STATE	10. IF SEPARATED BUT NOT DIVORCED, GIVE DATE AND CAUSE OF SEPARATION, AND STATE WHICH ONE LEFT THE OTHER.

11. HOW MANY TIMES WERE YOU MARRIED?	12. GIVE NAME OF EACH SPOUSE (*Include all former marriages*)	13. HOW WAS MARRIAGE TERMINATED? (*Check one in each case*)	14. DATE MARRIAGE WAS TERMINATED
		☐ DEATH ☐ DIVORCE	
		☐ DEATH ☐ DIVORCE	
		☐ DEATH ☐ DIVORCE	

(CONTINUED ON OTHER SIDE)

FILL IN PARTS D. AND E. ONLY IF YOU ARE NOT THE DESIGNATED BENEFICIARY OR THE WIDOW OR WIDOWER OF THE DECEASED.

PART D. INFORMATION CONCERNING NEXT OF KIN OF DECEASED

1. List below the name, age, relationship, and address of:

   (a) Widow or widower;

   (b) If there is no surviving widow or widower, list the child or children of all the deceased's marriages (including adopted child or illegitimate child, stating which class it is) or the descendants of deceased child or children;

   (c) If there are no children, list the surviving parent or parents;

   (d) If there are no survivors within the degrees indicated in (a) through (c), list the next of kin who may be capable of inheriting from the deceased (brothers, sisters, descendants of deceased brothers, sisters, etc.).

NAME	AGE	RELATIONSHIP TO DECEASED	ADDRESS

FILL IN BLANKS 2. AND 3. ONLY IF ANY OF THE PERSONS LISTED ABOVE ARE UNDER AGE 21.

2. IF A GUARDIAN HAS BEEN APPOINTED BY THE COURT FOR ANY MINOR CHILDREN ABOVE, GIVE NAME AND ADDRESS OF GUARDIAN AND ATTACH COPY OF THE APPOINTMENT PAPER ISSUED BY THE COURT.		3. IF A GUARDIAN HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED?
NAME	ADDRESS	☐ YES ☐ NO

PART E. INFORMATION CONCERNING THE ESTATE OF THE DECEASED

1. IF AN EXECUTOR OR ADMINISTRATOR HAS BEEN APPOINTED BY THE COURT TO SETTLE THE ESTATE OF THE DECEASED, GIVE NAME AND ADDRESS.		2. IF AN EXECUTOR OR ADMINISTRATOR HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED?
NAME	ADDRESS	☐ YES ☐ NO

PART F. CERTIFICATION BY CLAIMANT

1. Is claim being made for death benefits by accidental means (injuries solely sustained through violent, external and accidental means)? NO CLAIM FOR ACCIDENTAL MEANS BENEFITS CAN BE CONSIDERED UNLESS CORONER'S OR OTHER REPORTS OF INVESTIGATION AND NEWSPAPER CLIPPINGS WHICH ARE AVAILABLE CONCERNING THE ACCIDENT ARE ATTACHED. ☐ YES ☐ NO

I hereby certify that all statements made in this claim are true to the best of my knowledge, information and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld.

WARNING.—Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

____
(SIGNATURE OF CLAIMANT)

____
(NAME OF CLAIMANT—TYPE OR PRINT)

____
(NUMBER AND STREET)

____
(DATE)

____
(CITY, ZONE NUMBER, AND STATE)

INFORMATION REGARDING CLAIM FOR DEATH BENEFITS (Form FE-6)

FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ACT OF 1954, AS AMENDED

INSTRUCTIONS TO CLAIMANT

GENERAL –

To avoid delay:

(a) read the following instructions carefully;

(b) type or print in ink.

ORDER OF PRECEDENCE –

Payment of life and accidental death benefits under the Federal Employees' Group Life Insurance Act of 1954, as amended, must be made in the following order of precedence:

First, to the beneficiary designated by the insured;

Second, if there is no such beneficiary, to the widow or widower of the insured;

Third, if none of the above, to the child or children of the insured and descendants of deceased children by representation;

Fourth, if none of the above, to the parents of the insured or the survivor of them;

Fifth, if none of the above, to the duly appointed executor or administrator of the insured's estate;

Sixth, if none of the above, to the other next of kin of the insured entitled under the laws of domicile of the insured at the time of his death.

COMPLETION OF CLAIM –

All claimants must answer PART A–"General Information Concerning the Deceased." If you were designated in writing on Standard Form 54 as the beneficiary, you need not answer PARTS B through E. Otherwise, it is important that all questions be answered. Omissions or incomplete answers will delay settlement of the claim. If the answer to any question is "No" or "None," so state. In any event be sure to fill out PART F.

EVIDENCE REQUIRED –

There must be submitted with this claim a certified copy of the public record showing the death of the insured. This record may be obtained from the Bureau of Vital Statistics located in the State capitol, except in New York City where the record is maintained in the respective Borough Departments of Health, and in the State of Maryland where the records are kept in the city of Baltimore. Failure to submit death certificate will delay settlement of claim.

In addition, if the insured designated a beneficiary and a receipted copy of Standard Form 54 "Designation of Beneficiary" is available, this form should be submitted with the claim. The insured's Certificate of Group Insurance also should be submitted if it is readily available.

You will be informed if it becomes necessary to submit other evidence.

MANNER OF PAYMENT –

The entire amount of insurance is payable in a lump sum unless you state in a writing attached to this claim that you prefer payment in monthly (or annual) installments. If you indicate such a preference, you will be informed of the different settlement options available.

IF ASSISTANCE IS NEEDED

If you need assistance in completing this claim, contact the local personnel office of the department or agency in which the deceased was last employed, or the Office of Federal Employees' Group Life Insurance, 25 East 24th Street, New York 10, New York.

WHERE TO SEND CLAIM –

Forward completed claim to the local personnel office of the department or agency where the deceased was last employed or, if the deceased was retired, send the completed claim to the Bureau of Retirement and Insurance, United States Civil Service Commission, Washington 25, D. C.

INSTRUCTIONS TO EMPLOYING AGENCY

It is the agency's responsibility to assist the insured's beneficiary or next of kin in properly executing this claim. Upon completion, the agency should forward the claim and all required supporting evidence together with:

1. Original of Agency Certification of Insurance Status (S.F. 56);
2. Original of Designation of Beneficiary (S.F. 54), if any;
3. Waiver of Life Insurance Coverage (S.F. 53) and Request for Insurance (S.F. 51), if any;
4. Any other documents (except payroll records) bearing on the deceased employee's insurance status.

TO: Office of Federal Employees' Group Life Insurance
25 East 24th Street
New York 10, New York

Form No. DJ-51
(Rev. 8-16-57)

Department of Justice

POSITION AUTHORIZATION

Office of the United States Attorney for the __________ District of New Hampshire

Effective Date August 14, 1956

POSITIONS AUTHORIZED:

Serv., Grade and Series	Duty Station	Position Number	Title	No. of Positions Authorized
GS-301-6		54-F-503 (Brown)	Adm. Clerk	1
GS-301-5		55-F-52 (Jones)	Clerk (Steny.)	1
GS-312-4		55-F-53 (Smith)	Clerk (Steny.)	1

Total Authorization:

Non-Classified	
Classified	3
Temporary	
Total	3

This authorization is being made to reflect:

(x) Authorized forces approved in the F.Y. 1957 budget
( ) Reduction in positions for reason stated below.
( ) Additional positions requested on SF-52 as noted below.
( ) Other
Remarks:

Assistant to the Deputy Attorney General

Title 8

Note:

The Page 210 was not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 43 (front)

Standard Form 52—Rev. Dec. 1961
U.S. Civil Service Commission
FPM R-1

REQUEST FOR PERSONNEL ACTION

52-104

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part *except those inside the heavy lines*. If applicable, obtain resignation and separation data on reverse side.

1. NAME (CAPS) LAST—FIRST—MIDDLE MR.—MISS—MRS.	2. *(For agency use)*	3. BIRTH DATE *(Mo., Day, Year)*	4. SOCIAL SECURITY NO.
A. KIND OF ACTION REQUESTED: (1) PERSONNEL *(Specify appointment, reassignment, resignation, etc.)*		B. REQUEST NUMBER	C. DATE OF REQUEST
(2) POSITION *(Specify establish, review, abolish, etc.)*		D. PROPOSED EFFECTIVE DATE	E. POSITION SENSITIVITY
5. VETERAN PREFERENCE 1—NO 2—5 PT. 3—10 PT. DISAB. 4—10 PT. COMP. 5—10 PT. OTHER	6. TENURE GROUP	7. SERVICE COMP. DATE	8. PHYSICAL HANDICAP CODE
9. FEGLI 1—COVERED 2—INELIGIBLE 3—WAIVED	10. RETIREMENT 1—CS 2—FICA 3—FS 4—NONE 5—OTHER		11. *(For CSC use)*
12. NATURE OF ACTION CODE	13. EFFECTIVE DATE *(Mo., Day, Year)*	14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY	

15. FROM: POSITION TITLE AND NUMBER	16. PAY PLAN AND OCCUPATION CODE	17. GRADE OR LEVEL	18. SALARY
19. NAME AND LOCATION OF EMPLOYING OFFICE			

20. TO: POSITION TITLE AND NUMBER	21. PAY PLAN AND OCCUPATION CODE	22. GRADE OR LEVEL	23. SALARY
24. NAME AND LOCATION OF EMPLOYING OFFICE			

25. DUTY STATION *(City—county—State)*		26. LOCATION CODE
27. APPROPRIATION	28. POSITION OCCUPIED 1—COMPETITIVE SERVICE 2—EXCEPTED SERVICE	29. APPORTIONED POSITION FROM: 1—PROVED-1 2—WAIVED-2 TO: STATE

F. REMARKS BY REQUESTING OFFICE *(Continue in item F on reverse side, if necessary. Show, if applicable, any known additional or modified reasons for resignation)*

G. REQUESTED BY *(Signature and title)*	I. REQUEST APPROVED BY: SIGNATURE
H. FOR ADDITIONAL INFORMATION—CALL *(Name and telephone number)*	TITLE:

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J. POSITION CLASSIFICATION ACTION: IDENTICAL ADDITIONAL ☐ NEW ☐ VICE ☐ REGRADED ☐

K. CLEARANCES	Initials or Signature	Date	(7) REMARKS: *(Note: Use item 19 on reverse for Standard Form 50 remarks)*
(1)			QUALIFICATION STANDARD:
(2) CEIL. OR POS. CONTROL			
(3) CLASSIFICATION			
(4) PLACEMENT OR EMPL.			
(5)			
(6) APPROVED BY:			

FORM 43 (back)

STANDARD FORM 52
Revised December 1961

PART III. TO BE COMPLETED BY EMPLOYEE

RESIGNATION (*IMPORTANT—NOTE TO EMPLOYEE. Give specific reasons for your resignation. Avoid generalized reasons, such as "ill health," "personal reason."*)

I RESIGN FOR THE FOLLOWING REASONS: ______ (*Date resignation is written*)

THE EFFECTIVE DATE OF MY RESIGNATION WILL BE ______

______ (*Signature*)

PART IV. SEPARATION DATA

FORWARD COMMUNICATIONS, INCLUDING SALARY CHECKS AND BONDS, TO THE FOLLOWING ADDRESS:

(Street) (City) (Zone) (State)

PART I. (Continued)

F. REMARKS BY REQUESTING OFFICE:

PART II. (Continued)

19. STANDARD FORM 50 REMARKS

- ☐ SUBJECT TO COMPLETION OF 1 YEAR PROBATIONARY (OR TRIAL) PERIOD COMMENCING ______
- ☐ SERVICE COUNTING TOWARD CAREER (OR PERMANENT) TENURE FROM: ______
- ☐ SUCCESSOR POSITION—EMPLOYEE RETAINED IN THE COMPETITIVE SERVICE
- ☐ ENTRANCE PERFORMANCE RATING SATISFACTORY

SEPARATIONS: SHOW REASONS BELOW, AS REQUIRED. CHECK, IF APPLICABLE ☐ DURING PROBATION ☐ FROM APPOINTMENT OF 6 MONTHS OR LESS

☆ U.S. GOVERNMENT PRINTING OFFICE: 1961—O-612727 PS

Title 8

Note:

The Pages 213-218 were not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 45

Nature of Action	Effective Date	Position Title and Number	Grade and Salary or Group	Organizational Designation and Official Station
Prob. Appt.	3-1-51	Field Deputy Marshal 51-F-350	GS-5 3410	Marshals Office
P.S.I.	3-3-52	" "	" 3535	New York, N.Y.
"	3-4-53	" "	" 3660	"
Prom.	3-1-54	" 54-F-46	GS-6 3795	"

Card initially prepared by typewriter. All subsequent entries made by hand without removing card from file

FLAP OF CARD

Posted from Employee copy of DJ-50 prior to delivery to employee.

U.S. CIVIL SERVICE COMMISSION July 1949

EMPLOYEE RECORD CARD

Training, Skills, and Education

Efficiency Ratings: Date	Type	Rating	Date	Type	Rating	In-Service Training: Date	Course	Remarks
3-31-52	Reg.	S				3-5-53	Firearms	Score - 285
3-31-53	"	S					Qualification	
3-31-54	"	S						

Posted from Employee copy of Notification of Rating prior to delivery to employee.

BACK OF CARD

Physical Impairment:

Race: White

Emergency Addressee (name, address, telephone no.): Mrs. John F. Carter, 5412 Lexington Avenue, New York, New York - Mother

Address Change: | Tel. Change: | Marital Status: Single | CSC Status: No

Home Address: 5412 Lexington Avenue, New York, New York | Tel. No.: LE-1297 | Date of Birth: 6-10-23 | Veteran's Preference: Yes

Last Name—First Name—Middle Initial: Carter, Michael J. | Position Title: | Grade and Salary or Group:

This portion of card will not be used. It will be covered by the Position Identification Strip (SF-7D) for the position the employee is currently occupying.

POSITION TITLE AND NO.	SERIES	GRADE
Field Deputy Marshal 53-F-350	082	GS-

Standard Form 7D
Prescribed July 1949
By Civil Service Commission
Federal Personnel Manual
Chapter 3

POSITION IDENTIFICATION STRIP

Title 8

Note:

The Page 220 was not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

FORM 2159
MARCH [illegible]

U. S. TREASURY DEPARTMENT – INTERNAL REVENUE SERVICE

AGREEMENT FOR LIQUIDATION OF FEDERAL TAX THROUGH PAYROLL DEDUCTION

1. DEPARTMENT	2. DATE

3. BUREAU	4. NAME OF EMPLOYEE
5. PAYROLL OFFICE	6. HOME ADDRESS

7. ITEMIZATION OF DELINQUENT FEDERAL TAXES AND INTEREST

ACCOUNT NUMBER AND YEAR (a)	TAX (b)	INTEREST (c)	TOTAL (d)

For the purpose of paying the delinquent Federal taxes itemized above, including interest, in the total amount shown in item 8, I hereby agree to and authorize the deduction indicated in item 9 from each salary payment due me until the total of the indebtedness has been paid in full. This agreement shall become effective with the pay period beginning on the date shown in item 10 for the wages to be paid on the date shown in item 11.

If my employment should be terminated prior to liquidation of the total indebtedness, any lump sum payment due me shall first be applied to this debt before any payments are made to me.

8. Total amount of delinquent taxes itemized above	$
9. Amount authorized to be deducted from each salary payment until indebtedness is paid in full	$
10. Beginning date of pay period agreement becomes effective	
11. Date of payment of first wages affected by agreement	

12. SIGNATURE OF COLLECTION OFFICER	13. SIGNATURE OF EMPLOYEE

MAKE CHECK PAYABLE TO DISTRICT DIRECTOR, I. R. S., AND MAIL PAYMENT TO:

14. COLLECTION OFFICER

15. ADDRESS

FORM 48

Form No. USA-797
(Ed. 2-11-59)

DEPARTMENT OF JUSTICE

CERTIFICATE FOR COMPENSATION OF DETAINED WITNESS

United States vs. Witness:

_____________ District of _________________ Address:

I certify that the witness named above was detained under Rule 46b, Federal Rules of Criminal Procedure, from ___________ to ______________ and is entitled to $1 per day compensation for each day detained as provided by law (28 USC 1821). This certificate will be the Marshal's authority for payment.

No. days detained _____________

Compensation due $_____________

____
U. S. Attorney, Asst. U. S. Attorney
or U. S. Commissioner

FOR MARSHALS USE ONLY

Date Paid _________ Voucher No. _________

Amount Paid _______ Check No. __________

Date______________________

STANDARD FORM 51
REVISED JANUARY 19[illegible]
U. S. CIVIL SERVICE COMMISSION
CHAPTER I-8 F. P. M. ([illegible])

REQUEST FOR INSURANCE

FEDERAL EMPLOYEES' GROUP LIFE INSURANCE ACT OF 1954, AS AMENDED

CAREFULLY READ INSTRUCTIONS ON OTHER SIDE BEFORE COMPLETING THIS FORM.

TO: OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE

I hereby apply for cancellation of the *Waiver of Life Insurance Coverage* previously filed by me and request that I be insured under the Federal Employees' Group Life Insurance Act of 1954.

SIGNATURE OF EMPLOYEE (MUST BE SIGNED IN THE PRESENCE OF AN AUTHORIZED OFFICIAL OF YOUR EMPLOYING AGENCY OR AUTHENTICATED FROM OFFICIAL RECORDS)

ADDRESS (NUMBER AND STREET)

DATE

(CITY AND STATE)

PART A—TO BE COMPLETED BY EMPLOYING AGENCY

1. FULL NAME OF EMPLOYEE (LAST) (FIRST) (MIDDLE)

2. DATE OF BIRTH (MONTH) (DAY) (YEAR)

3. TITLE OF POSITION

4. AGENCY IN WHICH EMPLOYED, INCLUDING BUREAU OR DIVISION

5. LOCATION OF EMPLOYMENT (CITY AND STATE)

6. EFFECTIVE DATE OF EMPLOYEE'S LAST "WAIVER OF LIFE INSURANCE COVERAGE" (MONTH) (DAY) (YEAR)

7. WILL EMPLOYEE BE ELIGIBLE TO BECOME INSURED IF THIS "REQUEST FOR INSURANCE" IS APPROVED?
☐ YES ☐ NO

8. HAS EMPLOYEE HAD ANY CONTINUOUS ABSENCE OF AT LEAST 3 WEEKS ON ACCOUNT OF SICKNESS OR INJURY DURING THE PAST YEAR?
☐ YES ☐ NO

9. I CERTIFY THAT THE SIGNATURE APPEARING ABOVE IS THAT OF THE EMPLOYEE NAMED AND THAT THE ABOVE INFORMATION HAS BEEN OBTAINED FROM AND CORRECTLY *REFLECTS OFFICIAL RECORDS.*

(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL) (TITLE) (DATE)

(NAME OF AGENCY) (MAILING ADDRESS OF AGENCY)

PART B—TO BE COMPLETED BY EMPLOYEE

1. (A) ARE YOU NOW IN GOOD HEALTH?
☐ YES ☐ NO

1. (B) IF YOU ARE NOT NOW IN GOOD HEALTH, BRIEFLY STATE DETAILS.

2. (A) HAVE YOU BEEN TREATED BY ANY CLINIC, HOSPITAL, PHYSICIAN OR OTHER PRACTITIONER WITHIN THE *PAST 2 YEARS*?
☐ YES ☐ NO

2. (B) IF YOU HAVE BEEN TREATED, STATE THE DATE AND REASON.

3. HAVE YOU EVER BEEN DECLINED OR POSTPONED FOR LIFE OR HEALTH INSURANCE OR OFFERED A POLICY WITH A RATED-UP PREMIUM?
☐ YES ☐ NO

4. (A) HAVE YOU EVER HAD:	CHECK ONE			CHECK ONE		4. (B) IF YOUR ANSWER TO ANY PART OF QUESTION 4 (A) IS "YES," GIVE DATES, DURATION, AND OTHER DETAILS.
	YES	NO		YES	NO	
DIZZY OR FAINTING SPELLS			CANCER, TUMOR, OR GOITER			
TUBERCULOSIS, BRONCHITIS, OR PLEURISY			ULCERS OR GALLSTONES			
			DIABETES			
MENTAL OR NERVOUS DISORDER			EPILEPSY OR PARALYSIS			
BLOOD DISORDER			ANY OTHER PHYSICAL DEFECT OR DISEASE			

The answers I have given in Part B are for the purpose of securing approval of this "Request for Insurance" and I certify that they are true and complete to the best of my knowledge and belief.

SIGNATURE OF EMPLOYEE (MUST BE SIGNED IN THE PRESENCE OF THE EXAMINING PHYSICIAN) (DATE)

(OVER)

[illegible]

PART C—TO BE COMPLETED BY EXAMINING PHYSICIAN

PRINT EMPLOYEE'S FULL NAME			DATE OF BIRTH (MONTH) (DAY) (YEAR)	HEIGHT ______ INCHES	WEIGHT ______ LBS.	VISION (WITH GLASSES IF WORN) R ______ L ______
	NORMAL	ABNORMAL	BLOOD PRESSURE	PULSE		RESPIRATION
GENERAL APPEARANCE				AT REST ______		AT REST ______
NOSE, MOUTH AND THROAT			SYSTOLIC ______	IMM. AFTER EXERCISE ______		IMM. AFTER EXERCISE ______
LEGS (VARICOSITIES)						
SKIN			DIASTOLIC ______	2 MIN. AFTER EXERCISE ______		2 MIN. AFTER EXERCISE ______
MUSCULAR SYSTEM						
CARDIO-VASCULAR-RENAL SYSTEM			FULLY DESCRIBE ANY ABNORMALITIES NOTED OR ANY HISTORY OF ABNORMALITY YOU ARE ABLE TO ELICIT.			
RESPIRATORY SYSTEM						
GASTRO-INTESTINAL SYSTEM						
GENITO-URINARY SYSTEM						
NERVOUS SYSTEM						
SKELETAL SYSTEM						
GLANDULAR SYSTEM						
ENDOCRINE SYSTEM						
HERNIA	☐ YES	☐ NO	(IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEET)			

I certify that Part B was signed in my presence, that I have carefully examined the individual named above and that my complete findings on examination are correctly recorded above.

____
(SIGNATURE OF EXAMINING PHYSICIAN)

______________________________ ______________________________
(DATE OF EXAMINATION) (ADDRESS OF EXAMINING PHYSICIAN)

PART D—TO BE COMPLETED BY OFEGLI

TO THE EMPLOYING AGENCY: *The employee named on the reverse side may:*

☐ BE INSURED EFFECTIVE ON THE FIRST DAY HE IS IN A PAY STATUS AFTER THE DATE SHOWN BELOW. IF HE IS NOT IN A PAY STATUS WITHIN 31 DAYS FOLLOWING THAT DATE, THIS AUTHORIZATION IS VOID AND THE EMPLOYEE MAY NOT BE INSURED UNLESS A NEW REQUEST FOR INSURANCE IS APPROVED.

☐ NOT BE INSURED.

______________________________ ______________________________
(DATE OF APPROVAL) (APPROVING OFFICER)

INSTRUCTIONS

PLEASE READ CAREFULLY BEFORE FILLING OUT THIS FORM. FAILURE TO OBSERVE INSTRUCTIONS MAY RESULT IN DELAY.

TO THE EMPLOYING AGENCY

1. The employee is eligible to request insurance only if he is under age 50 and one year has elapsed since the effective date of his last S. F. 63 and he is not otherwise excluded from insurance coverage.
2. Have employee sign top part on reverse side of this form, then complete Part A and give the form to the employee.
3. Do not insure the employee until Part D has been approved by OFEGLI and returned to you.
4. The employee should be notified of OFEGLI's decision and the return form filed in the employee's OFFICIAL PERSONNEL FOLDER or its equivalent.

TO THE EMPLOYEE

1. Sign the top part on reverse side of this form and have your agency complete Part A.
2. Take the form to any medical doctor of your choice. Complete Part B and sign it in the presence of the doctor.
3. Have the doctor complete Part C.
4. The fee for the medical examination must be paid by you directly to the doctor.
5. The Office of Federal Employees' Group Life Insurance will notify your agency whether you may be insured and your agency will inform you of the decision.

TO THE EXAMINING PHYSICIAN

1. This examination is for Federal Employees' Group Life Insurance purposes.
2. The employee is to pay you the fee for this examination. Do not perform any special examinations or incur any unusual expense.
3. Have the employee sign Part B in your presence.
4. Fully complete, sign and date Part C. Unless specific findings are called for, indicate by check mark whether findings are normal or abnormal and describe any abnormalities in the space provided.
5. Do not return the form to the employee but mail it to the Office of Federal Employees' Group Life Insurance, 25 East 24th Street, New York 10, N. Y.

U. S. GOVERNMENT PRINTING OFFICE 16—86177-4

FORM 50
Form No. USA-150
(Rev. 1-25-56)

United States Department of Justice

UNITED STATES ATTORNEY

DEAR SIR: You are a witness in behalf of the Government in the case(s) specified below.

This letter is sent to you in lieu of service of subpoena. Please accept service of this notice by acknowledging same on the lower part of the duplicate hereof and return to me in the enclosed self-addressed envelope which requires no postage.

When you appear in answer to this letter please report to the address indicated below in order that your attendance may be certified. Upon being excused, you will be entitled to such fees and allowances as are provided by law.

Very truly yours,

United States Attorney.

Please report: Date........................ Time........................

Address:..

....

Case No. *Title of Case* *Action (Trial or Grand Jury)*

TO UNITED STATES ATTORNEY:

I accept service of this notice in lieu of subpoena and will be present accordingly at the time and place designated above.

....
(Witness signature)

June 1, 1956

FORM 51

Form No. USA-21
(Ed. 4-27-56)

PRAECIPE FOR SUBPOENA

United States District Court

________ DIVISION, ________ DISTRICT OF ________

THE UNITED STATES OF AMERICA
vs.
____
________ } No. ________

The Clerk of said Court will issue Subpoena directed to the United States Marshal for the ________ District of ________ for the following-named persons to appear before said Court/Grand Jury at ________ in ________, at ____ o'clock, ___. M., on the ________ day of ________, 19 ____, then and there to testify on behalf of the United States:

Names	*Addresses*

This ________ day of ________, 19____

Subpoena issued: ________, 19____

____
United States Attorney.

GPO 909827

FORM 52 (front)

Form No. DJ-3
(Rev. 2-10-60)

DEPARTMENT OF JUSTICE

REQUISITION FOR PRINTING OR REPRODUCTION OF SPECIAL FIELD FORMS
(See instructions on reverse)

TO: Forms and Reports Section
Management Office
Department of Justice
Washington, D. C.

_______ District of _______

Office of _______

City _______ State _______

Date _______

Inventory Number	Title of Form	Type of Paper	Number Requested	Number On Hand

Brief Description:

This order: (a) Is for new form ☐ Is a reprint ☐ Is a revision ☐

(b) Will be rerun ☐ Will not be rerun ☐

(c) Will last ____ months Last edition date _______

For Use of Forms and Reports Section

☐ Approved _______ Signature

☐ Disapproved _______ Date

Remarks:

_______ Signature of Requesting Officer

FORM 52 (back)

INSTRUCTIONS

1. Submit this requisition form in triplicate for printing of special forms. Do not use for ordering letterheads, envelopes, or stock forms.

2. A separate requisition must be used for each form desired (however, originals and copies of the same form should be listed separately on the same requisition).

3. Attach two copies of latest edition of form to be printed.

4. This requisition must be complete in all respects. The form number is particularly important.

5. If the number of copies of a form being ordered is less than 500, indicate under "Remarks" whether mimeographing will be satisfactory.

6. If request is for a new form, attach one copy of completed Form No. DJ-1 (Form Approval Request).

7. If a new form being requested is also a periodic report form as defined in Memo 216, Suppl. 1, attach one copy of completed Form No. DJ-4 (Application for Approval of Report).

8. If there is a similar form stocked by the Department or the Administrative Office of United States Courts, explain why it cannot be used, unless explanation has been made in connection with a previous order.

9. Correspondence relating to this requisition should be addressed to the Forms and Reports Section, Management Office.

FORM 53

Form No. DJ-53

Page 1 of

ORDER – INVOICE
GSA STORES STOCK

------ | days | Current date | JF- 2

U. S. Attorney/Marshal
DEPARTMENT OF JUSTICE
Federal Building
Brooklyn, New York

U. S. Attorney/Marshal
Department of Justice
Federal Building
Brooklyn, New York

B/L (or Shipping-Manifest No.)

GENERAL SERVICES ADMINISTRATION
Federal Supply Service
Region 2
250 Hudson Street
New York 13, New York
Department No. (indicate appropriate Dept. No.)

U. S. Attorney/Marshal
Department of Justice
Federal Building
Brooklyn, New York

PLEASE IDENTIFY ALL REMITTANCES BY GSA INVOICE NUMBER AND AMOUNT ON VOUCHER OR OTHER TRANSMITTAL.

SEE KEY TO ACTION CODE AT BOTTOM OF FORM.

STOCK NO. AND DESCRIPTION	QUANTITY ORDERED	UNIT OF ISSUE	UNIT PRICE	AMOUNT	ACTION CODE	SHIPPED QUANTITY	SHIPPED AMOUNT
LIST ITEMS (IN NUMERICAL SEQUENCE), QUANTITY, ETC.							

ACCOUNTING DATA 1570322
Sal. & Exp., U. S. Attys. & Marsh.,
Dept. of Justice, 1957
(Attorneys/Marshals)

TOTAL AMOUNT ORDERED $ INDICATE TOTAL OF ALL PAGES

TOTAL AMOUNT SHIPPED $

POSTAGE

TOTAL AMOUNT $

FUND TO BE CREDITED:
47X4530
GENERAL SUPPLY FUND

NAME John Doe (The name & title should be typed
TITLE U.S. Atty/Marsh. on 1st 5 pages only)

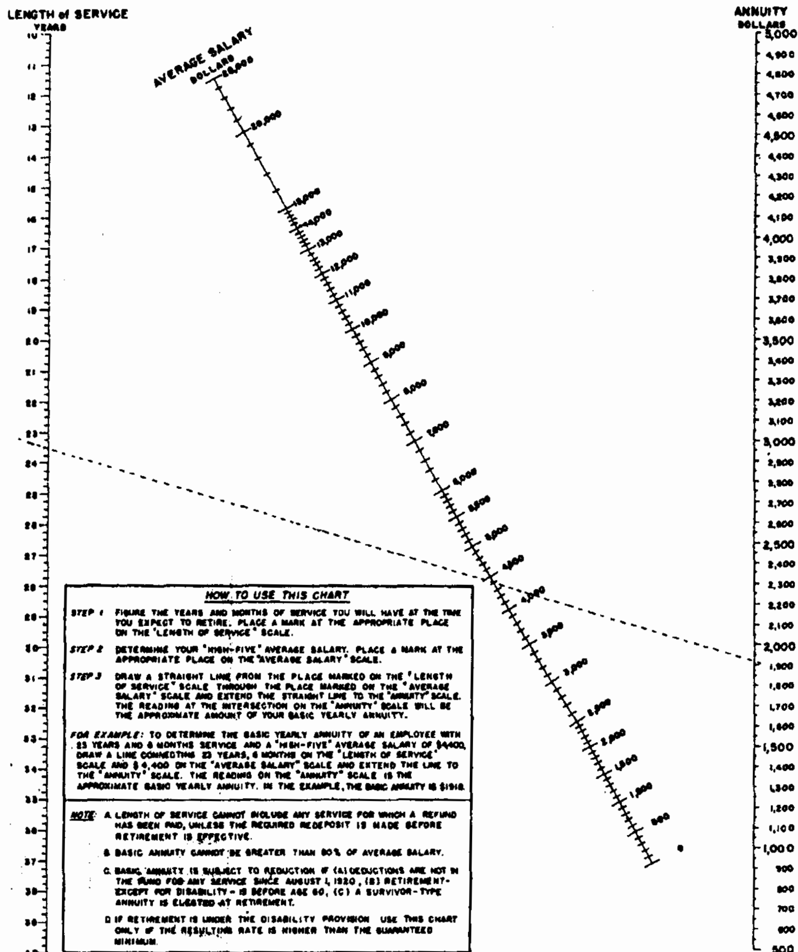
NOTE–PLEASE REFER TO GSA INVOICE NO. OR YOUR AGENCY ORDER NO. IN ALL CORRESPONDENCE OR INQUIRIES CONCERNING THIS ORDER.

KEY TO ACTION CODE ⟶
NO CODE -

1. ORIGINAL INVOICE

FORM 54

Annuity Ready Reckoner



FORM 55
Form No. DJ-52
(Ed. 4-7-58)

PERSONNEL INFORMATION SHEET

Grand Jury Reporting

District ______________________
City ______________________
Date ______________________

The following person will serve as grand jury reporter or will assist in performing or have available to him the grand jury reporting work under the Department of Justice:

Name ____
First Middle Last

Home Address ______________________________________

Date and place of birth ____________________________

Present business affiliation________________________

____

____
Attorney

The attorney who arranges for the reporting or a representative of his office will sign the form as the submitting officer. Ordinarily this will be the United States Attorney or a designated employee in his office, unless an attorney from the Department is responsible for presenting the matter before the grand jury.

FORM 56

ACCOUNTABLE PROPERTY

1. *Office Equipment*

   - Accounting machines
   - Adding machines
   - Addressing machines
   - Bookkeeping machines
   - Calculators
   - Cash register
   - Copyholders
   - Cylinder shavers
   - Dictating machines
   - Ditto machines
   - Duo-Photo machines
   - Duplicating machines
   - Envelope openers
   - Envelope sealers
   - Flags
   - Folding machines
   - Ledger trays
   - Meter mailing machines
   - Mimeograph machines
   - Mimeoscope machines
   - Multigraph machines
   - Multilith machines
   - Photostat machines
   - Posting trays
   - Power paper cutters
   - Scales (postal & platform)
   - Standard register
   - Stenomask machines
   - Shorthand machines
   - Timestamp machines
   - Transcribing machines
   - Trucks (folding, library, basket)
   - Vari-Type machines
   - Wire stitchers

2. *Books*

3. *Police Equipment*

   - Badges
   - Blackjacks
   - Bulletproof vests
   - Handcuffs
   - Lead chains
   - Leg irons
   - Machine guns
   - Restraining belts
   - Revolvers
   - Rifles
   - Shotguns
   - Straight jackets
   - Tear gas billies

NOTE: In addition to these principal items specified above there may be other items which will be considered accountable.

FORM 57
Form No. DJ-48
(Rev. 10-1-58)

DEPARTMENT OF JUSTICE

Residence Advice Sheet

To all United States Attorneys, Marshals and Assistant United States Attorneys:

In order that officials of the Department may be able to reach you by telephone, you are requested to notify the Department hereon, as to your office address, and its telephone number; your residence address, and telephone number, and to notify the Department hereafter of any change.

Deputy Attorney General.

Name ____

District ____

Office Address ________________________________
(Street)

____
(City) (Zone No.) (State)

Office Telephone No. ___________________________

Residence Address ______________________________
(Street)

____
(City) (Zone No.) (State)

Residence Telephone No. _________________________

Date ____

____

FORM 58 (front)

Standard Form No. 1143
7 GAO 5200
1143-105

ADVERTISING ORDER

No. ....

U. S. ...., 19 ......

The Publisher of ....

....

AUTHORITY TO ADVERTISE
Date ...., 19.....
No. ....

Sir:

You are hereby authorized to publish the enclosed advertisement relating to ....

....

to be set solid, without paragraphing, and without any display in the heading unless otherwise expressly authorized in the specifications attached to the advertisement, in the .... edition of your paper, ... times, prior to .... or on ....
(Give date on which publication is desired)
provided your rates are not in excess of the commercial rates charged to private individuals, with the usual discounts.

Respectfully,

INSTRUMENT OF ASSIGNMENT
Date ...., 19 .....
No. ....

....

Title ....

INSTRUCTIONS TO PUBLISHERS

Extreme care should be exercised to insure that the specifications for advertising to be set other than solid be definite, clear, and specific since no allowance will be made for paragraphing or for display or leaded or prominent headings, unless specifically ordered, or for additional space required by the use of type other than that specified. Specifications for advertising other than solid will accompany the advertisement copy submitted to the publisher with the advertising order and copies of both documents will be furnished to the General Accounting Office with the voucher. The following is a sample of solid line advertisement set up in accordance with the usual Government requirements.

TREASURY DEPARTMENT, Office of the Supervising Architect, Washington, D. C., May 16, 1913.—Sealed proposals will be received at this office until 3 o'clock p. m. on the 20th day of June, 1913, and then opened, for an electric vault-protection system in the United States post office at Indianapolis, Ind., in accordance with the specification, copies of which may be had at this office or at the office of the custodian at the discretion of the Supervising Architect, O. Wenderoth, Supervising Architect.

Your bill for this service should be rendered upon the voucher form printed on the reverse hereof immediately after the last insertion of the advertisement. The voucher, together with a marked copy of each issue of the paper containing the advertisement, should be addressed to

....

If copies of the publication are not available, it will be satisfactory if an affidavit of publication is furnished in lieu thereof.

IMPORTANT

Charges for advertising when a cut, matrix, stereotype, or electrotype is furnished will be based on actual space used and no allowance will be made for shrinkage.

In no case shall an advertisement extend beyond the date and edition herein named for publication.

☆ U.S. GOVERNMENT PRINTING OFFICE 1960 O—572727

FORM 58 (back)

PUBLIC VOUCHER FOR ADVERTISING

Voucher No. ....

PAID BY

U. S. ....
(Department or establishment, bureau or office)

Voucher prepared at ....
(Give date and place)

THE UNITED STATES, Dr., To ....
(Name of publication)

....
(Publisher or proprietor or his representative)

Address ....

To publication of attached advertisement in the above-named publication, as authorized by the attached Advertising Order, on

....

.... *as follows:*

AMOUNT — Dollars | Cts.

LINE RATES (.................. line): .... [1]{counted / space} LINES for first insertion
(Name of type) (Number)

at .... per line . . . . $..................

.... subsequent insertions of .... [1]{counted / space} LINES each at
(Number)

.... per line . . . . $..................

OTHER RATES (.............-point per ....): ....
(Size of type) (Inch, square, word, or folio) (Number of inches, squares, words, or folios)

for first insertion at .... per .... $..................
(Inch, square, word, or folio)

.... subsequent insertions of ....
(Number of inches, squares, words, or folios)

each at .... per .... $..................
(Inch, square, word, or folio)

Amount ....

Less discount at ....percent.

Amount due......

(Here paste advertisement clipped from publication, including upper and lower rules, on each copy of voucher)

I certify that the above attached advertisement appeared in the publication on ....
(Give dates advertisement was published)

and that the account as stated is correct and proper for payment.

[2] Approved for $..................

Date ....

....
(Authorized Certifying Officer)

Differences

....

....

....

Amount verified; correct for

(Signature or initials)..................

ACCOUNTING CLASSIFICATION (Appropriation Symbol must be shown; other classification optional)

Paid by Check No. ....

[1] Line out words not applicable.

[2] If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the blank space below "Approved for $..................," and over his official title.

FORM 59

Form No. OJ-1
(Rev. 1-21-60)

REQUEST FOR APPROVAL OF FORM

TO: FORMS AND REPORTS SECTION, MANAGEMENT OFFICE

DATE

FROM (Name)

DIVISION OR OFFICE

SECTION

PROPOSED FORM TITLE

FORM NUMBER (if known)

PURPOSE AND NEED (Explain fully)

PREVIOUS METHOD FOR SECURING INFORMATION

OTHER OFFICES PREPARING FORM

WRITTEN EXISTING AUTHORITY FOR FORM (Memo, Manual, letter, etc.)

INSTRUCTIONS FOR USE OF FORM WILL BE ISSUED
( ) YES (Attach copy) ( ) NO (Explain under "Remarks")

DATA TO BE ENTERED FROM (Include form numbers, if any)

DATA TO BE CARRIED TO (Include form numbers, if any)

RELATED FORMS IN USE (Attach copies)

RELATED FORMS TO BE DESIGNED LATER

REPORTS TO BE PREPARED FROM INFORMATION ON FORM

FORMS BEING SUPERSEDED, REVISED, OR ELIMINATED (Attach copy of each and mark appropriately)

AGENCIES, DIVISIONS, SECTIONS, OR OFFICES CONCERNED WITH FORM	CONCURRENCES (Check one) OBTAINED	UNNECESSARY

DISTRIBUTION OF FORM

COPY	SENT TO	USED FOR	RETENTION (if known) MOS. YRS.
Orig.-(1)			
2			
3			
4			
5			
6			
7			

REMARKS:

USE: ( ) Permanent ( ) Temporary ( ) One-Time

ESTIMATED SAVINGS BY USE OF FORM:______ man hours per year.

SIZE OF FORM:
Width ______
Length ______

NUMBER USED PER MONTH:
______ Originals
______ Copies

ENTRIES WILL BE MADE BY: ( ) pencil ( ) typewriter ( ) ink ( ) other

REQUESTING OFFICER SIGNATURE

DIVISION APPROVAL

FORMS CONTROL APPROVAL DATE

Title 8

Note:

The Pages 237-238 were not included in the print original.

Digital Services, DOJ Libraries, April 28, 2014

Form 60 (face)

Standard Form No. 2801-A Chapter R4 F. P. M.	SUPERIOR OFFICER'S STATEMENT IN CONNECTION WITH APPLICATION FOR TOTAL DISABILITY RETIREMENT CIVIL SERVICE RETIREMENT SYSTEM	[illegible]

This statement must be completed by the applicant's immediate superior officer and attached by the agency to his Application for Retirement (S. F. 2801) if the application is for retirement on account of total disability.

TO: SUPERIOR OFFICER.—To be eligible for disability retirement the applicant must become totally disabled for useful and efficient service in the grade or class of position last occupied by reason of disease or injury not due to vicious habits, intemperance, or willful misconduct on his part within the 5 years next prior to becoming so disabled. By answering the following questions as completely as you can you may help the Medical Officers of the Civil Service Commission considerably in determining whether the applicant is eligible and thereby avoid delay in processing his application.

1. NAME OF APPLICANT FOR DISABILITY RETIREMENT (*Last*) (*First*) (*Middle*)	2. HOW LONG HAVE YOU BEEN THE APPLICANT'S SUPERIOR OFFICER?

3. BRIEFLY DESCRIBE THE DUTIES AND RESPONSIBILITIES OF THE APPLICANT'S POSITION AND ALSO IMPORTANT ENVIRONMENTAL FACTORS CONNECTED WITH THE JOB. OR ATTACH OFFICIAL COPY OF JOB DESCRIPTION, IF MORE CONVENIENT.

4. WHICH OF THE DUTIES DESCRIBED IN ITEM 3 WAS THE APPLICANT UNABLE TO PERFORM ON ACCOUNT OF HIS DISABILITY?

5. AS FAR AS YOU WERE ABLE TO OBSERVE, HOW DID THE APPLICANT'S DISABILITY INTERFERE WITH OR PREVENT HIS PERFORMANCE OF THE DUTIES LISTED IN ITEM 4?

6. APPROXIMATELY HOW MANY DAYS HAS THE APPLICANT BEEN ABSENT BECAUSE OF ILLNESS WITHIN THE PAST 2 YEARS?

7. DESCRIBE ANY INSTANCES OF EMOTIONAL INSTABILITY OR ABNORMAL BEHAVIOR ON THE PART OF THE APPLICANT.

(CONTINUE ON OTHER SIDE)

Form 60 (back)

8. AS FAR AS YOU KNOW, HAS EXCESSIVE USE OF ALCOHOL OR DRUGS EVER INTERFERED WITH APPLICANT'S PERFORMANCE OF HIS DUTIES? IF SO, PLEASE GIVE DETAILS.

9. IF THE APPLICANT WAS FIRST HIRED WITH A PHYSICAL HANDICAP, PLEASE STATE WHETHER OR NOT THERE HAS BEEN ANY AGGRAVATION OF THE HANDICAP SINCE HE ENTERED ON DUTY. IF THE ANSWER IS "YES," PLEASE STATE WHEN SUCH AGGRAVATION WAS FIRST NOTICED AND TO WHAT DEGREE IT HAS NOW PROGRESSED.

10. PLEASE STATE ANY OTHER FACTS CONCERNING THE APPLICANT'S DISABILITY WHICH YOU FEEL MAY BE HELPFUL TO THE MEDICAL OFFICERS OF THE CIVIL SERVICE COMMISSION IN DETERMINING WHETHER THE APPLICANT MEETS THE ELIGIBILITY REQUIREMENTS FOR RETIREMENT ON ACCOUNT OF TOTAL DISABILITY.

11. WHAT EFFORTS HAVE BEEN MADE TO ASSIGN THE APPLICANT TO ANY OTHER JOB FOR WHICH HE IS QUALIFIED?

.... (SIGNATURE OF SUPERIOR OFFICER) .... (TITLE) .... (DATE)

.... (NAME OF AGENCY) .... (MAILING ADDRESS OF AGENCY)

NOTE: This completed statement must be attached by the employing agency to the Application for Retirement (S. F. 2801).

[illegible] GOVERNMENT PRINTING OFFICE : [illegible]—O—[illegible]

Form 61 (face)

Standard Form No. 2001-B Chapter R5 F. P. M.	PHYSICIAN'S STATEMENT IN CONNECTION WITH **APPLICATION FOR TOTAL DISABILITY RETIREMENT** CIVIL SERVICE RETIREMENT SYSTEM	6 GAO 3000 2001-301

INSTRUCTIONS TO APPLICANT

1. Complete PART A of this form.
2. After you have filled in PART A, give this form to your personal physician. PART B should be completed by the doctor and the form mailed by him to the address you have written in Item 4, PART A.
3. Your doctor's report is confidential and will be reviewed only by a medical officer of the Civil Service Commission.
4. Neither your employing office nor the Civil Service Commission can pay any expense incurred in completing this form. However, the Government will pay for any official examination which may later be required.

PART A.—TO BE COMPLETED BY APPLICANT

1. FULL NAME *(Last, middle, first—please type or print)*	2. DATE OF BIRTH *(Month, day, year)*

3. I HEREBY GIVE MY PERMISSION FOR YOUR RELEASE TO THE U. S. CIVIL SERVICE COMMISSION DIRECTLY OR THROUGH MY EMPLOYING OFFICE OF ANY OR ALL INFORMATION OR RECORDS CONNECTED WITH MY ILLNESS.

YOUR SIGNATURE	ADDRESS	DATE

4. IF NOT YET SEPARATED OR IF SEPARATED 30 DAYS OR LESS, GIVE THE NAME AND ADDRESS OF YOUR EMPLOYING OFFICE TO WHICH YOUR DOCTOR SHOULD SEND THIS REPORT. IF YOU HAVE BEEN SEPARATED MORE THAN 30 DAYS SHOW THE FOLLOWING NAME AND ADDRESS: RETIREMENT DIVISION, BUREAU OF DEPARTMENTAL OPERATIONS, U. S. CIVIL SERVICE COMMISSION, WASHINGTON 25, D. C.

NAME OF EMPLOYING OFFICE	NUMBER AND STREET	CITY, ZONE AND STATE

5. IF YOU ARE PRESENTLY EMPLOYED IN ANY JOB OTHER THAN YOUR FEDERAL (OR D. C.) GOVERNMENT POSITION GIVE DETAILS CONCERNING JOB, INCLUDING TYPE OF WORK PERFORMED.

PART B.—TO BE COMPLETED BY PHYSICIAN

DOCTOR: The Civil Service Retirement Law defines disability as meaning totally disabled for useful and efficient service in the grade or class of position last occupied by the employee by reason of disease or injury not due to vicious habits, intemperance, or willful misconduct on his part within the five years next prior to becoming so disabled.

In addition to observing the procedural instructions below, I ask your cooperation in making this report as comprehensive and objective as you can, particularly with respect to the condition which is considered totally disabling. The matter of retirement is of the utmost importance to the patient and the Government. If your report is complete and objective, our medical staff may be able to use it as a basis for deciding whether the patient is totally disabled. This would save delay and inconvenience to the employee of having to undergo an official examination as well as expense to the Government. Your report will be privileged and confidential. MEDICAL DIRECTOR, U. S. CIVIL SERVICE COMMISSION.

INSTRUCTIONS TO PHYSICIAN

1. Do not incur any expense to the Government in completing this statement.
2. Send completed form in a sealed envelope to address given by patient in Item 4 of PART A.
3. Mark envelope with name of patient and the words "Disability Retirement—Privileged—Private."
4. Your report will be opened and reviewed only by a medical officer of the Civil Service Commission.

1. PATIENT'S HEIGHT	2. WEIGHT	3. PHYSIOLOGICAL OR APPARENT AGE	4. MUSCULAR DEVELOPMENT	5. COLOR EYES	14. PULSE	15. RESPIRATION
6. COLOR HAIR	7. COMPLEXION	8. NUTRITION	9. POSTURE	10. GAIT	AT REST ____ IMM. AFTER EXERCISE ____	AT REST ____ IMM. AFTER EXERCISE ____
11. GENERAL APPEARANCE	12. TEMPERATURE	13. BLOOD PRESSURE SYSTOLIC ____ DIASTOLIC ____			3 MIN. AFTER EXERCISE ____	3 MIN. AFTER EXERCISE ____
					DO NOT EXERCISE IF CONTRAINDICATED	

(CONTINUE ON OTHER SIDE)

Form 61 (back)

PART B.—TO BE COMPLETED BY PHYSICIAN (Continued)

16. SINCE WHAT DATE HAS PATIENT BEEN UNDER YOUR PROFESSIONAL CARE FOR THE DISABILITY ON WHICH THIS APPLICATION IS BASED?
DATE

17. ON WHAT DATE DID YOU LAST SEE PATIENT FOR EXAMINATION OR TREATMENT?
DATE

18. WHAT HISTORY OF ONSET OF THE DISABILITY ON WHICH THIS APPLICATION IS BASED DID YOU ELICIT?

19. CAN PATIENT DO WORK INVOLVING DUTIES WHICH ARE: ☐ LIGHT ☐ MODERATE ☐ ARDUOUS?
OR DO YOU CONSIDER PATIENT TOTALLY DISABLED FOR ANY KIND OF WORK ☐ YES ☐ NO

IF YOU CONSIDER PATIENT TOTALLY DISABLED—

20. WHEN DID TOTAL DISABILITY BEGIN?
(DATE)

21. IS TOTAL DISABILITY INDEPENDENT OF INTEMPERANCE, VICIOUS HABITS, OR WILLFUL MISCONDUCT? ☐ YES ☐ NO

22 (A). IS TOTAL DISABILITY EXPECTED TO LAST ONE YEAR OR MORE? ☐ YES ☐ NO

22 (B). IF ANSWER IS "NO," GIVE PROBABLE DURATION.
(PROBABLE DURATION)

IF PATIENT IS OR RECENTLY WAS HOSPITALIZED, PLEASE STATE—

23 (A). NAME AND ADDRESS OF HOSPITAL OR SANATORIUM—

23 (B). DATE OF ADMISSION

23 (C). DATE OF DISCHARGE

24. PHYSICAL FINDINGS: Please describe objectively and in detail. If available, include the date of and a summary of any X-ray, fluoroscopic, e. k. g., e. e. g., blood count, blood chemistry, or such other laboratory data or pathologic findings on biopsy or operation as enabled you to arrive at the diagnosis shown below. If patient has nervous or mental disorder, include a neuropsychiatric summary. If patient was recently hospitalized a medical summary or abstract of the hospital records may be submitted in lieu of completing this side of the form. If you prefer you may use your own stationery to report your findings and diagnosis.

(If additional space is required, please continue on separate sheet)

25. DIAGNOSIS

26. REMARKS

SIGNATURE OF PHYSICIAN	ADDRESS	DATE

U. S. GOVERNMENT PRINTING OFFICE : [illegible]

Form 62
Form No. DJ-44a
(Rev. 9-12-60)

DEPARTMENT OF JUSTICE

Instructions Regarding Federal Employees' Group Life Insurance Upon Retirement

Your attention is called to certain benefits and privileges of annuitants as provided under the Federal Employees' Group Life Insurance Act.

The Federal Employees' Group Life Insurance Act extends coverage of life insurance only without cost to employees who retire because of disability, and those retiring on an immediate annuity after 12 or more years' creditable government service of which at least five were civilian. If you do not qualify as above (even though you are entitled to an immediate annuity), your insurance terminates 31 days after the effective date of your separation unless you convert to an individual policy.

Although you may qualify for continued life insurance coverage as a retired employee, you still have the privilege of converting to an individual policy in lieu thereof. In some instances this may be an advantage since at retirement, if age 65 or over, the face value of the policy reduces each month by 2 percent until the amount of insurance carried reaches 25 percent of the amount in force before the reduction. The amount of insurance obtainable under the conversion privilege may equal the amount of coverage at time of separation and you will not be required to undergo a medical examination. Policies issued under conversion may be in any form customarily issued by the insurance company issuing the policy, except Term Insurance and Disability or Accidental Death or Dismemberment Benefit Insurance.

There are attached original and one copy of Standard Form 55, Notice of Conversion Privilege. If you are interested in converting to an individual policy, write your name and current mailing address on the back of the copy and forward it immediately to the address shown on the form. You should hold the original until the Pay Roll Office returns the proper forms, with instructions, to be forwarded by you to the New York Office of the Federal Employees' Group Life Insurance. That office will advise you of the participating companies in your vicinity to contact.

It is important that you carefully read all information and instructions included in the forms pertaining to your insurance coverage since the time in which you may convert to an individual policy is limited.

November 1, 1960

Your attention is further called to the fact that any valid designation of beneficiary on file in the Department will be transferred to the Civil Service Commission with your retirement application. The designation will remain valid unless you wish to change or cancel it. If during retirement you wish to change or cancel your designation you should contact the Civil Service Commission. It is not necessary to file a designation of beneficiary unless you wish to name some person or persons not included in the order of precedence set forth on the reverse side of Standard Form No. 54, a copy of which is attached for your convenience.

If you desire further information concerning your insurance status, please contact the Personnel Office, Administrative Division, Department of Justice.

FORM 63

Form No. DJ-49
(Rev. 6-12-61)

REQUEST FOR
ARMED FORCES WITNESSES OR GOVERNMENT-EMPLOYEE WITNESSES
(United States Attorneys' Manual, Title 8, Page 120-122A)

TO: Administrative Assistant Attorney General, Attention A-7

FROM: ________________ Ext. ________ ________________
(Attorney making request) (Approving officer)

Please arrange for the attendance of the following named witness(es) stationed outside* the district in which the trial will be held:

Trial District________________ D.J. File No.________

Name of Case________________

Nature of Case________________

Government Agency________________

Name________________ Serial No.________

Last known address and date thereof________________

____

Name________________ Serial No.________

Last known address and date thereof________________

____

Witness should report to ________________ at
(office)

________________ on
(address)

________________ for a period of approximately ________ days.
(hour and date)

Gist of testimony________________

____

____

____

____

* If an Air Force witness will incur traveling expenses, this procedure of securing his attendance should be followed regardless of his location.

Call Extension 3547, Department of Justice, if this requires immediate action or if additional assistance is needed.

Note: Do not use this form for regular witnesses (United States Attorneys' Manual 8:118) or expert witnesses (United States Attorneys' Manual 8:125-129).

FORM 64

Standard Form 44a—June 1954 Edition
Prescribed by General Services
Administration Reg. 1-II-211

Approved by
Comptroller General, U. S.

PURCHASE ORDER—INVOICE—VOUCHER

PAID BY ☐ CASH OR CHECK NO.

D. O. VOUCHER NO.

BUREAU VOUCHER NO.

ORDER NO.

DATE OF ORDER

PRINT NAME AND ADDRESS OF SELLER (NUMBER, STREET, CITY AND STATE)

PAYEE

FURNISH SUPPLIES OR SERVICES TO (NAME AND ADDRESS)

QUANTITY	ITEM	UNIT PRICE	TOTALS

AGENCY NAME AND MAILING ADDRESS

TOTAL

DISCOUNT TERMS
% DAYS

DATE INV. RECEIVED

ORDERED BY (SIGNATURE)

PURPOSE (PROJECT, ETC.)

~~*I certify that the above bill is correct and just and that payment has not been received.~~

SELLER'S NAME ____________________

BY (SIGNATURE) ____________________

I certify that this account is correct and proper for payment in the amount of

$____________

(AUTHORIZED CERTIFYING OFFICER)

DIFFERENCES

ACCOUNT VERIFIED; CORRECT FOR . . . . .

BY ____________

APPROPRIATION, LIMITATION, PROJECT, OR OTHER ACCOUNTING CLASSIFICATION

1. SELLER'S INVOICE

*See instructions on Seller's Copy of Invoice

U. S. GOVERNMENT PRINTING OFFICE: 1963 O - 677822

FORM 65 (front)

STANDARD FORM NO. 2801
April 1963
FPM SUPPLEMENT 831-1

APPLICATION FOR RETIREMENT
CIVIL SERVICE RETIREMENT SYSTEM
(USE ONLY IF SEPARATED ON OR AFTER OCTOBER 11, 1962)

6 GAO 5000
2801-106

To avoid delay—1. Read information carefully; 2. Complete application in full; 3. Typewrite or print in ink

A. PERSONAL INFORMATION

1. NAME MR MRS MISS (*Last*) (*First*) (*Middle*)
2. DATE OF BIRTH (*Month*) (*Day*) (*Year*)
3. SOCIAL SECURITY NUMBER
4. ADDRESS (*Number and street*) (*City and State*) (*Zip Code*)
5. LIST ALL OTHER NAMES YOU HAVE USED
6. (A) ARE YOU A CITIZEN OF THE UNITED STATES OF AMERICA? ☐ YES ☐ NO
6. (B) IF "NO," OF WHAT COUNTRY ARE YOU A CITIZEN?
7. (A) ARE YOU MARRIED? ☐ YES ☐ NO
7. (B) IF "YES," GIVE THE FOLLOWING INFORMATION:

WIFE'S OR HUSBAND'S NAME (*First*) (*Middle*)	HER (OR HIS) BIRTH DATE (*Month*) (*Day*) (*Year*)	DATE OF MARRIAGE (*Month*) (*Day*) (*Year*)	PLACE OF MARRIAGE (*City and State*)	MARRIAGE PERFORMED BY ☐ CLERGYMAN OR JUSTICE OF THE PEACE ☐ OTHER (*Specify*)

B. CIVILIAN SERVICE

1. DEPARTMENT OR AGENCY IN WHICH PRESENTLY OR LAST EMPLOYED, INCLUDING BUREAU OR DIVISION
2. LOCATION OF EMPLOYMENT (*City and State*)
3. TITLE OF LAST POSITION
4. DATE OF FINAL SEPARATION (*Month*) (*Day*) (*Year*)
5. APPROXIMATE NUMBER OF YEARS OF CIVILIAN SERVICE
6. DO YOU HAVE FEDERAL EMPLOYEES GROUP LIFE INSURANCE? ☐ YES ☐ NO
7. ARE YOU ENROLLED IN A PLAN UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM? ☐ YES ☐ NO

C. MILITARY SERVICE

1. *COMPLETE THE SCHEDULE BELOW IF YOU HAVE PERFORMED ACTIVE DUTY THAT TERMINATED UNDER HONORABLE CONDITIONS IN ANY OF THE FOLLOWING SERVICES:* (A) ARMY, NAVY, MARINE CORPS, AIR FORCE, OR COAST GUARD OF THE UNITED STATES; OR (B) REGULAR CORPS OR RESERVE CORPS OF THE PUBLIC HEALTH SERVICE AFTER JUNE 30, 1960; OR (C) AS A COMMISSIONED OFFICER OF THE COAST AND GEODETIC SURVEY AFTER JUNE 30, 1961. IF AVAILABLE, ATTACH A COPY OF YOUR DISCHARGE CERTIFICATE.

BRANCH OF SERVICE	SERIAL NUMBER	DATE OF ENTRANCE ON ACTIVE DUTY	DATE OF SEPARATION FROM ACTIVE DUTY	LAST GRADE OR RANK	ORGANIZATION AT DISCHARGE (*Div., Regt., Co., etc.*)

2. (A) ARE YOU A MILITARY RESERVIST (*EITHER ACTIVE OR INACTIVE*)? ☐ YES ☐ NO
2. (B) ARE YOU IN RECEIPT OF OR HAVE YOU EVER APPLIED FOR *MILITARY RETIRED PAY? (RETIRED PAY DOES NOT INCLUDE V.A. PENSION OR COMPENSATION.)* ☐ YES ☐ NO
2. (C) IF "YES," WERE YOU RETIRED FROM A RESERVE COMPONENT UNDER CHAPTER 67, TITLE 10, U.S.C. (FORMERLY TITLE III, PUBLIC LAW 80-810)? ☐ YES ☐ NO

D. DISABILITY INFORMATION

Only applicants for total disability retirement will complete Part D.

1. WHEN DID YOU BECOME TOTALLY DISABLED? (*Month, year*)
2. BRIEFLY DESCRIBE YOUR DISABILITIES. STATE WHEN INCURRED, AND HOW THEY INTERFERE WITH PERFORMANCE OF THE DUTIES OF YOUR POSITION. (ATTACH ADDITIONAL COMMENTS ON PLAIN SHEET OF PAPER IF NECESSARY.)

E. OTHER CLAIM INFORMATION

1. (A) HAVE YOU EVER RECEIVED OR MADE APPLICATION FOR COMPENSATION UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT? ☐ YES ☐ NO
1. (B) IF "YES," STATE THE NUMBER OF YOUR COMPENSATION CLAIM AND THE PERIOD FOR WHICH YOU RECEIVED COMPENSATION

CLAIM NUMBER	FROM (*Month*) (*Day*) (*Year*)	TO (*Month*) (*Day*) (*Year*)

2. (A) HAVE YOU PREVIOUSLY FILED ANY APPLICATION UNDER THE CIVIL SERVICE RETIREMENT SYSTEM, INCLUDING APPLICATION FOR RETIREMENT, REFUND, DEPOSIT OR REDEPOSIT, OR VOLUNTARY CONTRIBUTIONS? ☐ YES ☐ NO
2. (B) IF "YES," INDICATE THE TYPE(S) OF APPLICATION AND GIVE THE CLAIM NUMBER(S) IF KNOWN
☐ RETIREMENT ☐ DEPOSIT OR REDEPOSIT ☐ REFUND ☐ VOLUNTARY CONTRIBUTIONS — CLAIM NUMBER(S)
3. (A) DO YOU HAVE LIFE INSURANCE THROUGH A FORMER EMPLOYEE BENEFICIAL ASSOCIATION FOR WHICH YOU NOW PAY PREMIUMS TO THE CIVIL SERVICE COMMISSION? ☐ YES ☐ NO
3. (B) IF "YES," GIVE YOUR ACCOUNT NO. B
4. (A) HAVE YOU EVER BEEN EMPLOYED UNDER ANOTHER RETIREMENT SYSTEM FOR FEDERAL OR DISTRICT OF COLUMBIA EMPLOYEES? ☐ YES ☐ NO
4. (B) IF "YES," GIVE THE NAME OF THE OTHER RETIREMENT SYSTEM

(OVER)

Form 65 (back)

INDICATE, BY SIGNING YOUR INITIALS IN THE APPROPRIATE BOX BELOW, THE TYPE OF ANNUITY YOU WANT TO RECEIVE. READ THE EXPLANATIONS AND CONSIDER THE MATTER CAREFULLY. NO CHANGE WILL BE PERMITTED AFTER AN ANNUITY HAS BEEN GRANTED. IF YOU WANT AN ANNUITY WITH A SURVIVOR BENEFIT, BE SURE TO GIVE THE OTHER INFORMATION CALLED FOR.

F. TYPES OF ANNUITY: MARRIED APPLICANTS ONLY

1. INITIALS [ ] **ANNUITY WITH SURVIVOR BENEFIT TO WIDOW OR WIDOWER**

SPECIFY THE PORTION OF YOUR ANNUITY YOU WANT USED AS THE BASE FOR YOUR WIDOW'S (OR WIDOWER'S) SURVIVOR ANNUITY.

If you want all your annuity used as the base for the survivor benefit, write the word "all" in the box below. If you want only part of your annuity used as the base for the survivor benefit, write the yearly amount of your annuity you want used.

$ [ ] THE SURVIVOR'S ANNUITY WILL BE 55% OF ALL OR WHATEVER PORTION OF YOUR ANNUITY YOU SPECIFY AS THE BASE FOR HER (OR HIS) BENEFIT.

- If you are married, you will receive this type of annuity unless you choose the annuity in F. 2.
- The annuity payable to you during your lifetime will be reduced by 2½% of any amount up to $3,600 a year used as the base for the survivor benefit, plus 10% of any amount over $3,600 so used.
- If you retire for total disability before age 60 and get a guaranteed minimum disability annuity, you may use all or any part of your "earned" annuity as the base for the survivor benefit. You cannot use any extra annuity which may be payable to make up the guaranteed minimum annuity.
- If your wife (or husband) should die before you, no change in type of annuity will be permitted, your annuity will not be increased, nor may you name any other person as survivor.
- The survivor's annuity will begin upon your death and end when she (or he) dies or remarries.

2. INITIALS [ ] **ANNUITY WITHOUT SURVIVOR BENEFIT**

(I do not desire my wife (or husband) to receive a survivor annuity benefit after my death.)

- If you choose this type, your wife (or husband) cannot be paid a survivor annuity after your death.
- This type provides annuity payments to you only.

G. TYPES OF ANNUITY: UNMARRIED APPLICANTS ONLY (Including Widowed and Divorced)

1. INITIALS [ ] **ANNUITY WITHOUT SURVIVOR BENEFIT**

- If you are not married, you will receive this type of annuity unless you choose the annuity in G. 2.
- This type provides annuity payments to you only.

2. INITIALS [ ] **ANNUITY WITH SURVIVOR BENEFIT TO NAMED PERSON HAVING AN INSURABLE INTEREST**

SPECIFY THE NAME, RELATIONSHIP AND DATE OF BIRTH OF THE PERSON YOU WISH TO RECEIVE THE SURVIVOR ANNUITY

NAME OF PERSON (*First, middle, last*)	
RELATIONSHIP	DATE OF BIRTH (*Mo., day, yr.*)

SEE UNMARRIED EMPLOYEES UNDER INFORMATION REGARDING SURVIVOR ANNUITIES ON THE ATTACHED INFORMATION SHEET FOR EXPLANATION OF REDUCTION IN YOUR ANNUITY.

- This type is available to all retiring *unmarried* employees who are *in good health*.
- It provides a reduced annuity to you and a survivor annuity to the person named as having an insurable interest.
- The survivor's annuity will begin upon your death and end when she (or he) dies.
- The survivor's annuity will be 55% of the reduced annuity you receive.
- If you choose this type, you will have to undergo a medical examination which will be arranged by the Civil Service Commission at no cost to you.
- If the person named as having an insurable interest should die before you, no change in type of annuity will be permitted, your annuity will not be increased, nor may you name any other person as survivor.

H. CERTIFICATION OF APPLICANT

WARNING.—Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001).

I hereby certify that all statements made in this application are true to the best of my knowledge and belief.

_______________ (DATE) _______________ (SIGNATURE OF APPLICANT)

I. FOR USE OF EMPLOYING AGENCY (See FPM Supplement 831-1 for instructions.)

CHECK APPROPRIATE BOX:

- [ ] INDIVIDUAL RETIREMENT RECORD, SF 2806, AND REGISTER OF SEPARATIONS AND TRANSFERS, SF 2807, ARE ATTACHED.
- [ ] INDIVIDUAL RETIREMENT RECORD, SF 2806, WAS SENT TO U.S. CIVIL SERVICE COMMISSION ON _______________ (DATE) WITH REGISTER OF SEPARATIONS AND TRANSFERS, SF 2807, NO. _______________.

_______________ (SIGNATURE) _______________ (OFFICIAL TITLE)

_______________ (DATE) _______________ (DEPARTMENT OR AGENCY)

OFFENSES BARRING ANNUITY PAYMENTS: Public Law 87-299 prohibits payment of annuity to persons who have committed specified offenses involving the national security of the United States. Employing agencies are responsible for submitting all pertinent information to the Civil Service Commission's Bureau of Retirement and Insurance in any case when this law possibly applies.

Form 66

Form C. A. 16

REQUEST FOR TREATMENT OF INJURY UNDER THE UNITED STATES EMPLOYEES' COMPENSATION ACT

Employees of the United States are entitled to medical, surgical, and hospital treatment under the provisions of the Compensation Act only for injuries sustained in the performance of duty.

...., 19......
(Date)

To.., ...
(Name of U. S. Hospital, U. S. Medical Officer, or Designated Physician) (Location)

THE BEARER, ...
(Name of injured employee)

is a civil employee of the United States, employed as ....
(Name of employee's occupation)

at ...., ...
(Name of office or establishment where employed) (Location)

He/She was injured in the performance of duty on ...., 19......
(Date)

Nature of injury ....

....

Treatment is requested for the results of said injury pursuant to the provisions of Section 9 of the United States Employees' Compensation Act.

....
(Signature of Official Superior)

....
(Title or official position)

....
(Address)

When this request is addressed to a designated physician or hospital, the reason why the request for treatment is not made to a United States medical officer or a United States hospital is to be noted

here ....

....

(See other side for provisions of the Compensation Act as regards treatment)

December 1961

FORM 67

Form C. A. 17

REQUEST FOR TREATMENT OF INJURY UNDER UNITED STATES EMPLOYEES' COMPENSATION ACT WHEN CAUSE OF INJURY IS IN DOUBT

Employees of the United States are entitled to medical, surgical, and hospital treatment under the provisions of the Compensation Act only for personal injuries sustained in the performance of duty.

................................, 19......
(Date)

To ...., ...
(Name of U. S. hospital, U. S. medical officer, or designated physician) (Location)

THE BEARER, ...
(Name of injured employee)

is a civil employee of the United States, employed as ....
(Name of employee's occupation)

at ....
(Name of office or establishment where employed) (Location)

There are reasons to believe that he was injured in the performance of duty on ....,
(Date)

19........ The alleged injury was due to ....
(Cause of injury)

....

The resulting disability appears to be ....
(Nature of disability)

....

You are requested to examine the case and advise this office whether in your opinion the disability is due to the alleged injury. If there seems reason to believe the disability may be due to injury alleged, treatment should be rendered as provided by Section 2.5 of the Bureau's Regulations until it can be definitely ascertained whether the case is one for which treatment should be continued under said regulations and the Compensation Act.

....
(Signature of official superior)

....
(Title or official position)

....
(Address)

(See other side for duties of official superior when using this form)

16—5658-3

December 1961

FORM 68

Form No. DJ-10
(Rev. 1-9-63)

UNITED STATES DEPARTMENT OF JUSTICE

REQUEST FOR AND AUTHORIZATION OF OFFICIAL TRAVEL

NO OFFICIAL TRAVEL MAY BE PERFORMED ON THE BASIS OF THIS REQUEST UNTIL THE CERTIFICATE OF AUTHORIZATION HAS BEEN SIGNED BY AN OFFICIAL EMPOWERED TO AUTHORIZE OFFICIAL TRAVEL.

Two copies of this order must be attached to the voucher submitted for per diem and reimbursement of expenses incident to official travel.

NAME OF TRAVELER

TITLE

DIVISION OR BUREAU

SECTION OR FIELD OFFICE | DATE

APPROXIMATE PERIOD OF TRAVEL | Leave on | Return on

PURPOSE OF TRAVEL

ITINERARY

PER DIEM RATE: $ .... per day

MODE OF TRAVEL
(Check type requested)

(*a*) ☐ By common carrier.

(*b*) ☐ By privately owned automobile on a mileage basis at the rate of ....¢ per mile.

☐ Not to exceed cost via common carrier.

☐ It having been determined that such mode of travel is more advantageous to the Government.

(*c*) ☐ By Government-owned automobile.

(*d*) ☐ ....

ESTIMATED COST

Transportation . . . $..................

Per diem . . . .

Other . . . .

Total . . . . . $..................

REQUESTED BY:

....

....
(Title)

CERTIFICATE OF AUTHORIZATION

You are authorized to travel at Government expense in accordance with the regulations of the Department of Justice and the standardized Government travel regulations as amended, under the conditions outlined in this order.

Appropriation chargeable:

....

....
(Title)

Approved as to funds:

....

FISCAL CONTROL NO. ....

FORM 69

REGULATIONS FOR OFFICE TRAVEL
BETWEEN OFFICE, RESIDENCE, AND BUSINESS DESTINATION

1. <u>In the morning, travel beginning at residence</u>

If the distance between residence (R) and first point of duty (D) (jail, service of process, court, etc.) is greater than residence (R) to headquarters (H), the excess mileage is allowed; plus mileage from first point of duty to headquarters. Examples A, B, C, and D.

2. <u>In the evening, travel beginning at headquarters</u>

Mileage will be allowed from headquarters (H) to last point of duty (D); plus excess mileage between last point of duty (D) and residence (R) over distance between residence and headquarters. Examples E, F, G, H, and I.

3. <u>Travel not involving headquarters</u>

Mileage will be allowed from whatever point travel begins to place of last duty and return to point of departure or residence. Example J.

4. <u>Travel outside prescribed work hours</u>

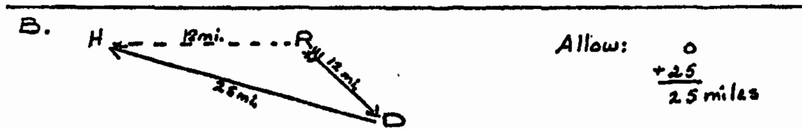
On a non-workday if called back to duty outside prescribed work hours, round-trip mileage will be allowed from point travel begins (including residence) to point of duty if that point is not solely the office. Examples J and K.

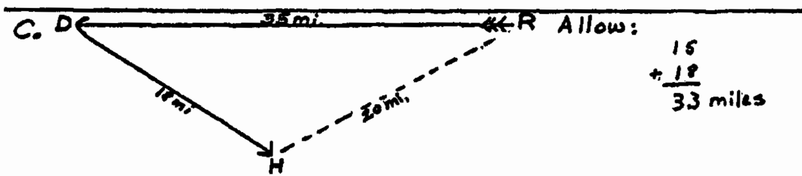
FORM 69 (Cont.)

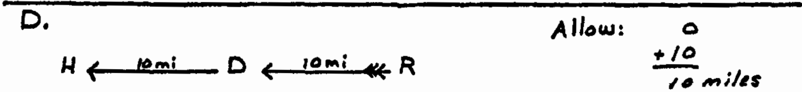
Examples

R - Residence
D - Duty
H. - Headquarters

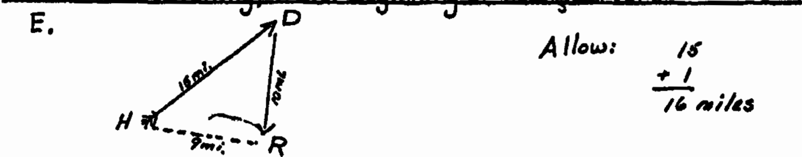
Morning, Travel Beginning at Residence





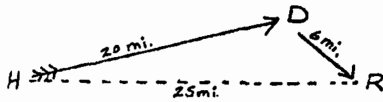


Evening, Travel Beginning at Headquarters



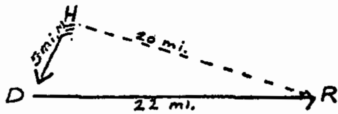
FORM 69 (Cont.)

F.



Allow: 20
+ 0
20 miles

G.

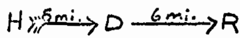


Allow: 5
+ 2
7 miles

H.

Allow: 5
+ 5
10 miles

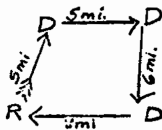
I.



Allow: 5
+ 0
5 miles

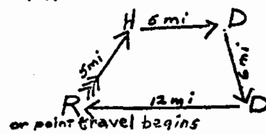
Not Involving Headquarters or Outside Prescribed Hours

J.



Allow: 5
5
6
8
24 miles

K.



Allow: 5
5
6
12
28 miles

FORM 70

Form No. DJ-78
(Ed. 12-20-63)

REQUEST AND AUTHORIZATION
FOR AUTOMOBILE OR AIRCRAFT RENTAL

NAME AND SIGNATURE OF TRAVELER	DIVISION	DATE
CHECK ONE ☐ AUTOMOBILE ☐ AIRCRAFT	ESTIMATED RENTAL PERIOD	ESTIMATED COST
PLACE(S) OF TRAVEL	FOR PURPOSE OF	

JUSTIFICATION

(Include why other mode of travel cannot be used and affirmative statement of advantage to the Government.)

The above request is approved. Record your travel on Form DJ-79 in duplicate. Attach this authorization, and both copies of Form DJ-79 to your travel voucher.

DATE	SIGNATURE AND TITLE OF APPROVING OFFICER

FORM 71

Form No. DJ-79
(Ed. 12-20-63)

DAILY LOG FOR AUTOMOBILE OR AIRCRAFT RENTAL
(Prepare in duplicate for each day)

RENTAL AGENCY	PLACE OF RENTAL	RENTAL AGREEMENT NUMBER

RENTER (Name shown on rental agreement) | DATE RENTED

PLACE OF DEPARTURE, PLACES VISITED, AND FINAL DESTINATION

OTHER PASSENGERS, AND REMARKS

DEPARTURE		ARRIVAL		* MILES ON OFFICIAL TRAVEL
TIME	METER READING	TIME	METER READING	

*Additional mileage on personal business: _______ miles.

DATE ______________ SIGNATURE OF TRAVELER ______________________