

Assassination Records Review Board Final Determination Notification

AGENCY : HSCA
RECORD NUMBER : 180-10060-10470
RECORD SERIES : STAFF PAYROLL RECORDS
AGENCY FILE NUMBER :

Released under the John F.
Kennedy Assassination
Records Collection Act of
1992 (44 USC 2107 Note).
Case#:NW 68261 Date:
09-01-2022

December 8, 1995

Status of Document: Postponed in Part

Number of releases of previously postponed information: 6

Reason for Board Action: The Review Board's decision was premised on several factors including: (a) the significant historical interest in the document in question; (b) the absence of evidence that the release of the information would cause harm to the United States or to any individual.

Number of Postponements: 3

Postponements: All the postponements in this document represent Social Security numbers.

Reason for Board Action: The text is redacted because the public disclosure of the redaction could reasonably be expected to constitute an unwarranted invasion of personal privacy, and that invasion of privacy would be so substantial that it outweighs the public interest.

Substitute Language: SSN

Date of Next Review: 2017

Board Review Completed: 10/24/95

JFK ASSASSINATION SYSTEM

IDENTIFICATION FORM

AGENCY INFORMATION

AGENCY : HSCA
RECORD NUMBER : 180-10060-10470

RECORDS SERIES :
STAFF PAYROLL RECORDS

AGENCY FILE NUMBER :

DOCUMENT INFORMATION

ORIGINATOR : HSCA
FROM :
TO :

TITLE :

DATE : 10/11/77
PAGES : 7

SUBJECTS :
HSCA, ADMINISTRATION
LICHTENFELS, BETH ANNE

DOCUMENT TYPE : PRINTED FORM
CLASSIFICATION : U
RESTRICTIONS : 3
CURRENT STATUS : P
DATE OF LAST REVIEW : 06/04/93

OPENING CRITERIA :

COMMENTS :
Box 2.

[R] - ITEM IS RESTRICTED

PAYROLL AUTHORIZATION FORM

(Please Use Typewriter
or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES
Washington, D.C. 20515

(Any erasures, corrections, or changes
on this form must be initialed by the
authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	Effective Date
Beth Anne Lichtenfels	March 1, 1978
Employee Social Security Number	Type of Action
JFK Act 5 (g) (2) (D)	<input type="checkbox"/> Appointment <input checked="" type="checkbox"/> Salary Adjustment <input type="checkbox"/> Title Change <input type="checkbox"/> Termination (At close of business on effective date) <input type="checkbox"/> Leave without pay (Beginning with effective date above and ending close of business _____) <small>Specify Date</small>
Employing Office or Committee/Subcommittee	
Assassinations	

(If type of action is an Appointment, Salary Adjustment, or Title Change, complete appropriate information below.)

Position Title	Gross Annual Salary*
Document Control Clerk	\$14,000

* If employee is a civil service annuitant (includes U.S. House of Representatives), the gross annual salary shown should include the annuity received by the employee plus the salary received from the employing office.

(If Committee Employee, complete appropriate item below.)

- Standing Committee: Staff— Clerical or Professional.
- Special (Investigative staff of Standing Committee) or Select Committee: Authority—H. Res. 956 of 95th Congress.
- Joint Committee.

(If Employee of an Officer of the House, complete item below.)

Position Number _____ If applicable, Level _____ Step _____

I certify that this authorization is not in violation of 5 U.S.C. 3110(b), prohibiting the employment of relatives.

Date March 14, 19 78

[Handwritten Signature]
(Signature of Authorizing Official)

(If appropriate, signature of Subcommittee Chairman or Ranking Minority Member)

LOUIS STOKES

(Type or print name of Authorizing Official)

Chairman

(Type or print name and title of above official)

(Title - If Member, District and State)

All appointments and salary adjustments for employees under the House Classification Act and for Committee employees, except those of the Committee on Appropriations, the Committee on the Budget, and the Joint Committees, must be approved by the Committee on House Administration.

APPROVED: _____

Chairman, Committee on House Administration

Office of Finance use only:	
Office Code _____	ID _____
Monthly Annuity \$ _____ .00 as of _____	Benefits _____
	Payroll _____

(Revised: August 1, 1977)

Copy for Initiating Office or Committee

MEMORANDUM

TO: ALL STAFF

RE: Payroll Certification

The Regulations and Accounting Procedures for Allowances and Expenses of Committees, Members and Employees of the U.S. House of Representatives require that, among other things, the Committee's monthly payroll certification include the relationship, if any, of each employee to any current Member of Congress. This certification is signed monthly by our Chairman.

The following are the relationships to be included in the certification:

father	nephew	brother-in-law
mother	niece	sister-in-law
son	husband	stepfather
daughter	wife	stepmother
brother	father-in-law	stepbrother
sister	mother-in-law	stepsister
uncle	son-in-law	half-brother
aunt	daughter-in-law	half-sister
first cousin		

Please complete the appropriate portion below, sign and date this form, which will then become a part of your permanent personnel file. If this status changes, you must notify the Committee's Budget Office immediately of the change.

I am not related to any current (95th Congress) Member of Congress.

I am related to a current (95th Congress) Member of Congress.
(Please specify.) _____

Ann Anne Lichtenfels
Signature of Employee

Oct. 11, 1977
Date

M E M O R A N D U M

TO: Tom Howarth, Budget Officer
FROM: Charlie Mathews, Special Counsel
DATE: October 5, 1977
RE: Ms. Beth Anne Lichtenfels

J.E.M.

Ms. Beth Anne Lichtenfels has accepted the position of Document Control Clerk with the John F. Kennedy Task Force. Her effective starting date will be October ¹¹ 7, 1977, and her starting salary will be \$12,000.00.

Your full co-operation will be appreciated in familiarizing Ms. Lichtenfels with staff procedures and welcoming her aboard.

ICM:jl

PAYROLL AUTHORIZATION FORM

(Please Use Typewriter
or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES
Washington, D.C. 20515

(Any erasures, corrections, or changes
on this form must be initialed by the
authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	Effective Date
Beth Anne Lichtenfels	October 11, 1977
Employee Social Security Number	Type of Action
JFK Act 5 (g) (2) (D)	<input checked="" type="checkbox"/> Appointment <input type="checkbox"/> Salary Adjustment <input type="checkbox"/> Termination (At close of business on effective date)
Employing Office or Committee	
Assassinations	

(If type of action is an Appointment or Salary Adjustment; complete the following information.)

Position Title	Gross Annual Salary
Document Control Clerk	\$12,000.00

(If Committee Employee, complete appropriate item below.)

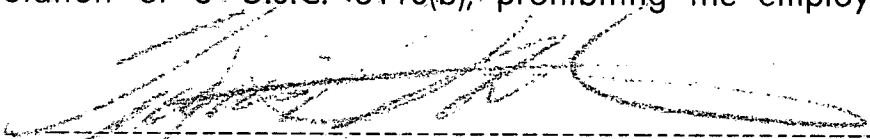
1. Standing Committee: Staff— Clerical or Professional.
2. Special or Select Committee: Authority—H. Res. 465 of 95th Congress.
3. Joint Committee.

(If Employee of an Officer of the House, complete item below.)

Position Number _____ If applicable, Level _____ Step _____

I certify that this authorization is not in violation of 5 U.S.C. 3110(b), prohibiting the employment of relatives.

Date October 11, 1977



(Signature of Authorizing Official)

Louis Stokes

(Type or print name of Authorizing Official)

Chairman

(Title—If Member, District and State)

All appointments and salary adjustments for employees under the House Classification Act and for Committee employees, except those of the Committee on Appropriations, the Committee on the Budget, and the Joint Committees, must be approved by the Committee on House Administration.

APPROVED: _____

Chairman, Committee on House Administration

Office of Finance use only: Office Code _____ Monthly Annuity \$ _____ .00
--

Copy for Initiating Office or Committee

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency HOUSE OF REPRESENTATIVES	22. Bureau or Office SELECT COMMITTEE ON ASSASSINATIONS
---	---

23. Name and Address of Reporting Office (No., street, city, state, Zip Code)
HOUSE ANNEX #2 3rd AND D STREET, WASHINGTON, D.C.

24. Regular Work Day Begins <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM Ends <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	25. Number of Hours Worked Per Day 8	26. Circle Days Paid Per Week S (M) (T) (W) (T) (F) S
---	--	--

27. Date and Hour of Injury (mo., day, year) 7/19/78 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	28. Date Reporting Office Received Notice of Injury (mo., day, year) 7/19/78	29. Date and Hour Stopped Work (mo., day, year)	30. If Pay Has Been Terminated, Give Date (mo., day, year)
---	--	---	--

31. 45 Day Period Begins (mo., day, year)	32. Pay Rate When Employee Stopped Work \$ _____ per _____	33. Date and Hour Employee Returned to Work (mo., day, year) <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM 7/19/78	34. Name of Supervisor At Time of Injury T. HOWARTH
---	--	---	---

35. Was Employee In Performance of Duty At The Time of Injury? Yes, No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
 Yes No. If Yes, Furnish Detailed Report.

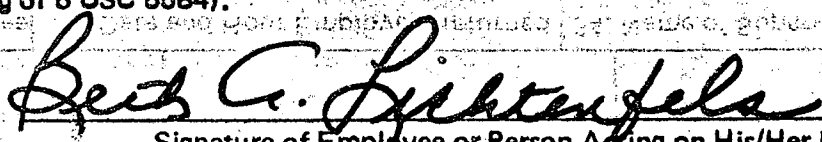
37. Was Injury Caused By Third Party? Yes No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury (mo., day, year) 7/19/78	39. Name and Address of Physician First Providing Medical Care SUBURBAN HOSPITAL EMERGENCY ROOM BETHESDA, MARYLAND	40. Do Medical Reports Show Employee is Disabled For Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
---	--	--

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
 Yes No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? Yes No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor <i>Thomas Howarth</i>	44. Title and Office Phone Number Budget Officer 225-2980	45. Date (mo., day, year) 7-27-78
--	---	---

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION	
1. Name of Injured Employee (Last, first, middle) LICHTENFELS, BETH ANNE		2. Date of Birth 1/5/55	3. <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		4. Social Security Number 042-52-4602	
5. Employee's Home Mailing Address (No., street, city, state, zip code) 4401 EAST WEST HWY, BETHESDA, MD. APT 300		6. Home Telephone Area Code: 301 Number: 654-7184	
7. Name and Address of Employing Agency House SELECT COMM. ON ASSASSINATIONS 3rd AND D STREET, S.W. WASHINGTON, D.C.		8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine) 2nd AND C STREET WASHINGTON, D.C.	
9. Date and Hour of Injury (mo., day, year) 7/17/78 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	10. Date of This Notice (mo., day, year) 7/27/78	11. Dependents Wife/Husband <input type="checkbox"/> Children Under 18 Years Old <input type="checkbox"/>	12. Employee's Occupation Doc. Clerk
13. Cause of Injury (Describe how and why the injury occurred) Fall was caused by faulty shoe strap which broke and tripped injured employee		14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.) Partially separated right shoulder torn rotating cuff, torn and bruised tendons, ligaments and muscles. Skin burn to right shoulder	
15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay. 			
16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work: <input type="checkbox"/> a. Sick and/or annual leave <input type="checkbox"/> b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).			
		 Signature of Employee or Person Acting on His/Her Behalf	
17. Statement of Witness (Describe what you saw, heard or know about this injury) 			
18. Witness' Signature		19. Witness' Address	20. Date Signed (mo., day, year)

