

# Assassination Records Review Board Final Determination Notification

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AGENCY : HSCA  
RECORD NUMBER : 180-10068-10337  
RECORD SERIES : STAFF PAYROLL RECORDS  
AGENCY FILE NUMBER :

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**December 8, 1995**

**Status of Document:** Postponed in Part

**Number of releases of previously postponed information: 8**

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: 6**

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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

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**Board Review Completed: 10/24/95**

JFK ASSASSINATION SYSTEM

IDENTIFICATION FORM

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AGENCY INFORMATION

AGENCY : HSCA  
RECORD NUMBER : 180-10068-10337

RECORDS SERIES :  
STAFF PAYROLL RECORDS

AGENCY FILE NUMBER :

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DOCUMENT INFORMATION

ORIGINATOR : HSCA  
FROM :  
TO :

TITLE :

DATE : 12/14/78  
PAGES : 15

SUBJECTS :  
HSCA, ADMINISTRATION  
DOYLE, KEVIN SEAN

DOCUMENT TYPE : PRINTED FORM  
CLASSIFICATION : U  
RESTRICTIONS : 3  
CURRENT STATUS : P  
DATE OF LAST REVIEW : 07/07/93

OPENING CRITERIA :

COMMENTS :  
Box #:1.

-----  
[R] - ITEM IS RESTRICTED

DOYLE, K.S. ✓  
Name of Employee

OFFICE OF THE CLERK  
U.S. HOUSE OF REPRESENTATIVES  
PERSONAL LEAVE RECORD

BALANCE BROUGHT  
FORWARD FROM  
PRECEDING YEAR

Annual Leave	Sick Leave
-	-

1977

YEAR

DATE OF APPOINTMENT

12-14-76

ANNUAL LEAVE  
CATEGORY

1.0 ☐

1.5 ☐

2.0 ☐

PRIOR FEDERAL SERVICE

Years Months

Position Number

Level

Step

Month	DAY OF MONTH																															Annual Leave	Sick Leave	Annual Leave	Sick Leave	Annual Leave	Sick Leave	Annual Leave	Sick Leave	EMPLOYEE INITIALS
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31									
Jan.																																	/	/					/	/
Feb.																																/	/					2	2	
Mar.																																/	/					3	3	
Apr.																																/	/					4	4	
May																																/	/					5	5	
June						X	X	X	X	X	X		S						S				S								/	/	6	6	5	3	1	3		
July				X																	A										/	/	2	4	1	0	1	4		
Aug.																																								
Sept.																																								
Oct.																																								
Nov.																																								
Dec.																																								

Terminated 8/16/77

- ☒ = 0.5 day annual leave  
☒ = 1.0 day annual leave  
☒ = 0.5 day sick leave  
☒ or ☒ = 1.0 day sick leave  
☒ = 0.5 day administrative leave  
☒ or ☒ = 1.0 day administrative leave  
☒ = 0.5 day unauthorized absence  
☒ or ☒ = 1.0 day unauthorized absence  
☒ = 0.5 day leave without pay  
☒ = 1.0 day leave without pay

CERTIFIED CORRECT:

Employee's Signature  
(If employee refuses to sign, state reason below.)

Date

Chief's Signature

Date

Approved:

Clerk of the House

Date

This record will be forwarded to the Clerk of the House at the end of each calendar year, or in case of termination, along with the request for termination. Upon approval, the record will be filed in the employee's official personnel folder.

EXHIBIT I

**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:

<b>Employee Name (First-Middle-Last)</b> Kevin Sean Doyle	<b>Effective Date</b> 8/16/77
<b>Employee Social Security Number</b> JFK Act 5 (g) (2) (D)	<b>Type of Action</b> <input type="checkbox"/> Appointment <input type="checkbox"/> Salary Adjustment <input checked="" type="checkbox"/> Termination (At close of business on effective date)
<b>Employing Office or Committee</b> Assassinations Committee	

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

<b>Position Title</b> Clerical Assistant	<b>Gross Annual Salary</b> \$9,500.00
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(If Committee Employee, complete appropriate item below.)

- ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
- ☒ Special or Select Committee: Authority—H. Res. 465 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 August 17, 1977, 19

(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**

**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:

<b>Employee Name (First-Middle-Last)</b>	<b>Effective Date</b>
Kevin Sean Doyle	8/1/77
<b>Employee Social Security Number</b>	<b>Type of Action</b>
JFK Act 5 (g) (2) (D)	<input type="checkbox"/> Appointment
<b>Employing Office or Committee</b>	<input checked="" type="checkbox"/> Salary Adjustment
Assassinations	<input type="checkbox"/> Termination (At close of business on effective date)

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

<b>Position Title</b>	<b>Gross Annual Salary</b>
Clerical Assistant	9,500

(If Committee Employee, complete appropriate item below.)

- ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
- ☒ Special or Select Committee: Authority—H. Res. 465 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 August 2, 19 77

(Signature of Authorizing Official)

LOUIS STOKES, C

(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

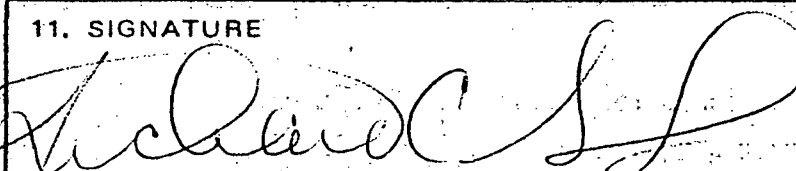
Office of Finance use only:

Office Code \_\_\_\_\_

Monthly Annuity \$ \_\_\_\_\_ .00

Copy for Initiating Office or Committee

- mailed 4/22/77

U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs		DUTY STATUS REPORT	
PART A - SUPERVISOR			
1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE MEDICAL SERVICES Richard Smith 21-56-49 3-24-77			
2. EMPLOYEE'S NAME (Last, first, middle) OWCP 7-23-55 M 26	3. DATE OF INJURY (Mo., day, year) 3/24/77	4. OCCUPATION Clerical Assistant	5. SOCIAL SECURITY NUMBER JFK Act 5 (g) (2) (D)
6. DESCRIPTION OF INJURY  right ankle twisted			
PART B - PHYSICIAN			
7. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ABLE TO RESUME WORK.			
8. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE BRIEFLY THE PHYSICAL LIMITATIONS WHICH ARE DUE TO THE INJURY.			
9. IF THE EMPLOYEE IS FIT FOR NEITHER FULL OR LIGHT DUTY, GIVE A BRIEF REPORT AND PROGNOSIS			
10. REMARKS Excess walking may remain painful for a couple of days			
11. SIGNATURE 	12. PROFESSIONAL DEGREE MD	13. DATE (Mo., day, year) Mar 24, 1977	
PART C - SUPERVISOR			
14. SEND A COPY OF THIS REPORT TO:  U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs		15. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.  Select Committee on Assassinations House of Representatives Washington, D.C. 20515	

-mailed 4/22/77

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF FEDERAL EMPLOYEES' COMPENSATION		FEDERAL EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE	
1. NAME OF INJURED EMPLOYEE (Last, first, middle) <b>DOYLE KEVIN SEAN</b>		2. DATE OF BIRTH (Mo., day, year) <b>7/23/55</b>	3. <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE
		4. SOCIAL SECURITY NUMBER JFK Act 5 (g) (2) (D)	
5. HOME MAILING ADDRESS (Number, street, city, state, zip code) <b>224 N. WAKEFIELD, ARL., VA. 22203</b>		6. HOME TELEPHONE AREA CODE NUMBER	
7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT (Name, number, street, city, state, zip code) <b>SELECT COMM. ASSASS</b>			
8. PLACE WHERE INJURY OCCURRED (e.g., 2nd floor, building 402, Andrews Air Force Base) <b>3rd FLOOR 3337 HOB #2</b>			
9. DATE AND HOUR OF INJURY (Mo., day, year) <b>3/24/77</b> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		10. DATE OF THIS NOTICE (Mo., day, year) <b>3/24/77</b>	
		11. OCCUPATION <b>CLERICAL ASSISTANT</b>	
12. CAUSE OF INJURY (Describe how and why injury occurred) <b>Caught foot on hole in carpet and twisted ankle</b>			
13. NATURE OF INJURY (Name part of body affected—fractured left leg, bruised right thumb, etc.) <b>right ankle hurt + has lump</b>			
14. NAMES OF WITNESSES TO INJURY (If none, so state) <b>NONE</b>			
15. 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.		16. SIGNATURE OF INJURED EMPLOYEE OR PERSON ACTING ON HIS BEHALF <b>Kevin Sean Doyle</b>	
17. STATEMENT OF WITNESS: DESCRIBE WHAT YOU SAW, HEARD OR KNOW ABOUT THIS INJURY			
		18. SIGNATURE OF WITNESS	19. DATE (Mo., day, year)

**CA-1 & 2**

Rev. May, 1973

OFFICIAL SUPERIOR'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

20. DEPARTMENT OR AGENCY HOUSE OF REP		21. BUREAU OR OFFICE S.C. on Assass													
22. NAME AND MAILING ADDRESS OF REPORTING OFFICE (Name, number, street, city, state, zip code)															
23. DATE REPORTING OFFICE RECEIVED NOTICE OF INJURY (Mo., day, year) 3/24/77 <input type="checkbox"/> VERBAL <input checked="" type="checkbox"/> WRITTEN	24. NAME OF SUPERVISOR IN CHARGE WHEN INJURY OCCURRED DONOVAN GAY	25. NAME AND TITLE OF PERSON TO WHOM NOTICE FIRST GIVEN Bob MORRISON DEP DIRECTOR OF SEC													
26. DATE AND HOUR OF INJURY (Mo., day, year) 3/24/77 100 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	27. CIRCLE DAY OF WEEK WHEN INJURY OCCURRED S M T W <b>(T)</b> F S	28. HOUR REGULAR WORK BEGINS 900 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM													
29. HOUR REGULAR WORK ENDS 600 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	30. NUMBER HOURS WORKED PER DAY 9	31. CIRCLE DAYS PAID PER WEEK S <b>(M)</b> <b>(T)</b> <b>(W)</b> <b>(T)</b> <b>(F)</b> S													
32. DATE AND HOUR STOPPED WORK (Mo., day, year)  <input type="checkbox"/> AM <input type="checkbox"/> PM	33. DATE AND HOUR PAY STOPPED (Mo., day, year)  <input type="checkbox"/> AM <input type="checkbox"/> PM	34. DATE AND HOUR RETURNED TO WORK (Mo., day, year)  <input type="checkbox"/> AM <input type="checkbox"/> PM													
35. INCLUSIVE DATES EMPLOYEE RECEIVED PAY FOR THE PERIOD HE DID NOT WORK (Mo., day, year) <table style="width:100%; border: none;"> <tr> <td style="width:33%; text-align: center;">ANNUAL LEAVE</td> <td style="width:33%; text-align: center;">SICK LEAVE</td> <td style="width:33%; text-align: center;">OTHER</td> </tr> <tr> <td>FROM TO</td> <td>FROM TO</td> <td>FROM TO</td> </tr> <tr> <td>FROM TO</td> <td>FROM TO</td> <td>FROM TO</td> </tr> <tr> <td>FROM TO</td> <td>FROM TO</td> <td>FROM TO</td> </tr> </table>				ANNUAL LEAVE	SICK LEAVE	OTHER	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO
ANNUAL LEAVE	SICK LEAVE	OTHER													
FROM TO	FROM TO	FROM TO													
FROM TO	FROM TO	FROM TO													
FROM TO	FROM TO	FROM TO													
36. WAS THE EMPLOYEE ENGAGED IN HIS USUAL OCCUPATION AT THE TIME THE INJURY OCCURRED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, FURNISH DETAILED EXPLANATION															
37. WAS THE EMPLOYEE IN PERFORMANCE OF DUTY AT TIME OF INJURY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, FURNISH DETAILED EXPLANATION OR A COPY OF THE EMPLOYING ESTABLISHMENT'S INVESTIGATION REPORT															
38. WAS THE INJURY CAUSED BY WILLFUL MISCONDUCT, INTOXICATION OR INTENT TO BRING ABOUT INJURY TO SELF OR ANOTHER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH DETAILED EXPLANATION															
39. WAS THE INJURY CAUSED BY A THIRD PARTY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, FURNISH NAME AND ADDRESS OF RESPONSIBLE PARTY															
40. DATE EMPLOYEE FIRST OBTAINED MEDICAL CARE FOR THE INJURY (Mo., day, year) 3/24/77	41. NAME AND ADDRESS OF FIRST ATTENDING PHYSICIAN														
42. DOES YOUR KNOWLEDGE OF THE FACTS ABOUT THIS INJURY AGREE WITH THE STATEMENTS OF THE EMPLOYEE AND/OR WITNESS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF NO, FURNISH DETAILED EXPLANATION															
43. SIGNATURE OF OFFICIAL SUPERIOR 	44. TITLE CHIEF RESEARCHER	45. DATE (Mo., day, year) 3/24/77													

CA-1 & 2

Rev. May, 1973



**INSTRUCTIONS FOR COMPLETING FEDERAL EMPLOYEES' NOTICE OF  
INJURY OR OCCUPATIONAL DISEASE, CA-1 & 2**

**IMPORTANT:** Employee and official superior should read all of the following instructions before the page is removed.

Items 1 through 16 of this form should be completed by the injured employee or by someone acting on his behalf, whenever an injury is sustained in the performance of duty. The term injury includes occupational disease caused by the employment. The form should be given to the employee's official superior within 48 hours following the injury. The official superior is that individual having responsible supervision over the employee.

In instances of a recurrence of disability resulting from an injury previously reported on form CA-1 & 2, the official superior should complete and submit form CA-2a.

The official superior will complete the "Receipt of Notice of Injury" at the bottom of this page, tear off the page, and give it to the employee. The official superior will also be responsible for obtaining the statement of a witness (if any), signature, and date, in items 17, 18 and 19 on the front of the form.

A brief description of benefits provided by the Federal Employees' Compensation Act is given on the back of this page.

**INSTRUCTIONS FOR COMPLETING OFFICIAL SUPERIOR'S  
REPORT OF INJURY OR OCCUPATIONAL DISEASE, CA-1 & 2**

The back of form CA-1 & 2 should be completed by the employee's official superior. The form should be sent immediately to the Office of Federal Employees' Compensation servicing the employing establishment if:

1. The injury causes disability for the employee's usual work beyond the shift it occurred, or
2. It appears that the injury will result in prolonged treatment, permanent disability or serious disfigurement of the head, face or neck, or
3. It appears that the injury will result in a charge for medical or other related expense.

If none of the above occurs or appear likely to occur, the form should be filed in the employee's official personnel file after the official superior completes the "Receipt of Notice of Injury" and gives it to the employee.

When additional information is required to explain or clarify any point, attach supplemental statements to the form. The form should then be sent to the appropriate office of the Bureau. For further information, see the regulations governing the administration of the Federal Employees' Compensation Act (Code of Federal Regulations Title 20 Chapter 1).

**RECEIPT OF NOTICE OF INJURY**

THIS ACKNOWLEDGES RECEIPT OF NOTICE OF INJURY SUSTAINED BY

KEVIN SEAN DOYLE  
(Name of injured employee)

WHICH OCCURRED ON

3/24/77  
(Mo., day, year)

AT

3337 HOB #2  
(Location)

SIGNATURE OF OFFICIAL SUPERIOR

TITLE

DATE

Dennis J. Dwyer

CHIEF RESEARCHER

3/24/77  
3/24/77

**CA-1 & 2**

Rev. May, 1973

**OFFICIAL SUPERIOR'S REPORT OF INJURY OR OCCUPATIONAL DISEASE**

20. DEPARTMENT OR AGENCY

HOUSE

21. BUREAU OR OFFICE

# CA-1 & 2

Rev. May, 1973

## DISABILITY BENEFITS FOR EMPLOYEES UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT

The Federal Employees' Compensation Act administered by the Office of Federal Employees' Compensation (OFEK) provides the following basic disability benefits for employment related injuries or occupational diseases:

1. Full medical care.
2. Payment of compensation for wage loss.
3. Payment of compensation for permanent impairment of certain members or functions of the body (such as loss or loss of use of an arm, loss of hearing, etc.) or for serious disfigurement of the head, face or neck.
4. Vocational rehabilitation and related services where necessary.

Medical care must be obtained from United States medical officers and hospitals when available and practicable. Otherwise, from any duly qualified private physician or hospital of the employee's choice. Qualified physicians may be used only if U.S. or designated medical facilities are not available, or if an emergency exists.

Compensation is paid by check sent to the employee's home mailing address. Compensation for wage loss is payable only for periods when an employee is in a non-pay status. The first three days in a non-pay status are waiting days and no compensation is paid for these days unless the period of disability exceeds 21 days or the employee has suffered a permanent disability. Compensation is generally paid at the rate of 2/3 of an employee's salary if he has no dependents, or 3/4 of his salary if he has one or more dependents.

Compensation is not paid automatically—an employee or someone acting on his behalf must claim it by filing OFEC form CA-4. This form may be obtained from the employing establishment or the OFEC. In practically all cases medical reports are required before compensation may be paid, therefore arrangements should be made to have medical reports submitted to the OFEC at the earliest possible date.

If an employee stops work as a result of an employment related injury or occupational disease, he may:

1. Use sick and/or annual leave, or
2. Receive compensation from the OFEC.

Before compensation may be paid, the OFEC must receive form CA-1 & 2; form CA-4; and medical evidence concerning the nature and causal relationship of the injury. Medical reports must cover initial examination and the employee's condition at the time claim for compensation is filed. In addition, if a case involves some complication or conflicting information, it may be necessary to obtain supplemental information.

An employee or someone acting on his behalf must complete the front of the form CA-1 & 2 and file it within one year after the injury or disease occurs. However, under certain circumstances, the OFEC may waive the one-year requirement if the front of the CA-1 & 2 is completed and the form filed within five years.

If an employee is in doubt about his compensation benefits, he may write to the Office of Federal Employees' Compensation servicing the employing establishment. (Obtain the address of the OFEC office from the employing establishment).

**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:

<b>Employee Name (First-Middle-Last)</b>	<b>Effective Date</b>
<b>Kevin Sean Doyle</b>	<b>1/3/77</b>
<b>Employee Social Security Number</b>	<b>Type of Action</b>
JFK Act 5 (g) (2) (D)	<input checked="" type="checkbox"/> Appointment
<b>Employing Office or Committee</b>	<input type="checkbox"/> Salary Adjustment
<b>Select Committee on Assassinations</b>	<input type="checkbox"/> Termination (At close of business on effective date)

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

<b>Position Title</b>	<b>Gross Annual Salary</b>
<del>NAKKA</del> <b>Clerical Assistant</b>	<b>\$9,000.00</b>

(If Committee Employee, complete appropriate item below.)

- ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
- ☒ Special or Select Committee: Authority—H. Res. 222 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 \_\_\_\_\_, 19\_\_\_\_

(Signature of Authorizing Official)

Henry B. Gonzalez

(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

# 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
Kevin Sean Doyle	12/14/76
Employee Social Security Number	Type of Action
JFK Act 5 (g) (2) (D)	<input checked="" type="checkbox"/> Appointment
Employing Office or Committee	<input type="checkbox"/> Salary Adjustment
Select Committee on Assassinations	<input type="checkbox"/> Termination (At close of business on effective date)

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

Position Title	Gross Annual Salary
Messenger	\$9,000

(If Committee Employee, complete appropriate item below.)

- ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
- ☒ Special or Select Committee: Authority—H. Res. 1540 of 94th 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 December 15, 1976

(Signature of Authorizing Official)

Thomas H. Downing, Chairman

(Type or print name of Authorizing Official)

Select Committee on Assassinations

(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

M E M O R A N D U M

TO: All Staff Employees  
FROM: Budget Officer  
DATE: January 3, 1977  
RE: Payroll Certification

Starting with the January, 1977 payroll, the certification to the House Finance Office requires, among other things, the relationship, if any, of each staff employee to any current Member of Congress (those taking office January 3, 1977).

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

father  
mother  
son  
daughter  
brother  
sister  
uncle  
aunt  
first cousin

nephew  
niece  
husband  
wife  
father-in-law  
mother-in-law  
son-in-law  
daughter-in-law

brother-in-law  
sister-in-law  
stepfather  
stepmother  
stepbrother  
stepsister  
half-brother  
half-sister

All staff employees are requested to complete this form and return it to the Budget officer.

Approved  
Richard A. Sprague

I am not related ✓

I am related by the following relationship \_\_\_\_\_

Kevin Sean Doyle  
Signature of Employee

1/7/77  
Date

RESUME OF  
KEVIN SEAN DOYLE

Present Address: 224 N. Wakefield Drive  
Arlington, Virginia 22203

Date of Birth: July 23, 1955

Marital Status: Single

Sex: Male Height: 6'2" Weight: 190 lbs.

Health: Excellent

Telephone: Office - 225-4624

EDUCATION

9/75 - 6/76 SUNY at Buffalo

1/75 - 6/75 University of Iowa (Writers' Workshop)

9/73 - 10/73 State University of N.Y. at Buffalo (SUNY)  
year leave of absence

9/67 - 6/73 Nichols School (Grades 7-12)

WORK EXPERIENCE

8/75 - 10/75 Dog Census Bureau (City of Buffalo)  
Census Taker (left because we counted all dogs)

6/75 - 8/75 Mayor's Summer Youth Program  
City of Buffalo  
Stockroom Supervisor (terminated-seasonal job)

1/74 - 5/74 Bartender in bars owned by Dennis Brinkworth  
Buffalo, New York (left to travel abroad)

8/73 - 12/73 Doyle, Diebold, Bermingham, Gorman, & Brown  
(law firm - left to find another job)

6/73 - 8/73 Laborer, Buffalo Sewer Authority (seasonal job)

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RESUME

Kevin Sean Doyle

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SPECIAL INTERESTS

Writing, photography, music (guitar, piano), cinema

REFERENCES

Furnished upon requests

RESUME OF  
KEVIN SEAN DOYLE

Present Address: 224 N. Wakefield Drive  
Arlington, Virginia 22203

Date of Birth: July 23, 1955

Marital Status: Single

Sex: Male Height: 6'2" Weight: 190 lbs.

Health: Excellent

Telephone: Office - 225-4624

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9/75 - 6/76 SUNY at Buffalo

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