U.S. Department of Transportation
Maritime Administration

REPORT OF INVESTIGATION OF SERIOUS ILLNESS/INJURY

OMB Control No. 9000-0077
Public reporting burden of this collection of information is estimated to average one hour per response. Send comments regarding this burden estimate or any other aspect of this information collection to the Maritime Administration, Office of Management Services, 400 Seventh St, SW, Room 7225, Washington, DC 20590, and to the Office of Management and Budget, Paperwork Reduction Project (9000-0077), Washington, DC 20503.

Ship manager	Vessel	Voyage ID

Seafarer's name	Social Security Number	"Z" number	Age

Residence address (street, city, ZIP code)

Type of voyage	Date articles commenced	Date articles terminated
❒ foreign ❒ coastwise ❒ intercoastal ❒ not applicable		

Rating	Ship's department	Job type
		❒ permanent ❒ relief ❒ other

Supervisor (name)	Supervisor's rating

Date of investigation	Time	Name of investigator	Investigator's rating

Remarks of investigator as to cause(s) of incident

Is injury/illness in any way due to misconduct?	If YES, describe	Was seafarer logged?
❒ Yes ❒ No ❒ Not known		❒ Yes ❒ No

COMPLETE FOR ANY INJURY/ILLNESS WHICH INCAPACITATES SEAFARER FOR 24 HOURS OR MORE

Date of illness/injury	Time	Nature of illness/injury	
Date first reported	**Time**	**To whom (name)**	**Crew member's rating**

Location of vessel at time of incident	Seafarer's duty status
❒ in port ❒ at sea ❒ at anchorage	❒ on duty ❒ off duty ❒ working overtime ❒ other

COMPLETE FOR ANY ACCIDENT RESULTING IN INJURY WHICH INCAPACITATES SEAFARER FOR 24 HOURS OR MORE

If accident occurred aboard ship, exact location on ship where accident occurred

Ship's equipment involved in accident. If none, write "NONE"

Condition of any ship's equipment involved in accident	Condition of accident scene at time of investigation
❒ new ❒ good ❒ fair ❒ repair needed ❒ replacement needed	

Name of crew member at or near accident scene (attach signed statement)	Crew member's rating
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IF SEAFARER SENT ASHORE FOR MEDICAL TREATMENT, ATTACH COPY OF COMPLETED REPORT OF ATTENDING DENTIST OR PHYSICIAN

Medical officer (please print)	Signature	Date
Department head (please print)	**Signature**	**Date**
Master (please print)	**Signature**	**Date**