



U.S. Department of Transportation  
Maritime Administration

# INITIAL REPORT OF PERSONAL 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 Street, S.W., 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 number	Date of report	
Type of incident <input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY		Date of incident	Date first reported	To whom reported (name)		
		Time of incident (local)	Time first reported (local)	To whom reported (rating)		
Seafarer's last name		First name	Middle name(s)	Social Security Number		
Rating		Job type <input type="checkbox"/> permanent <input type="checkbox"/> relief		Foreign voyage		
Lost time accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Watches missed Days missed	Was medical care provided <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical care provided aboard <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical care provided ashore <input type="checkbox"/> Yes <input type="checkbox"/> No	Date sent ashore Time sent ashore	Detached from vessel <input type="checkbox"/> Yes <input type="checkbox"/> No
Pertinent entries made in: <input type="checkbox"/> medical log <input type="checkbox"/> deck log <input type="checkbox"/> engine log <input type="checkbox"/> official log						
Duty/watch status <input type="checkbox"/> day <input type="checkbox"/> regular <input type="checkbox"/> overtime <input type="checkbox"/> off duty			Weather conditions <input type="checkbox"/> clear <input type="checkbox"/> fog <input type="checkbox"/> rain <input type="checkbox"/> snow <input type="checkbox"/> other			
Location where accident occurred: <input type="checkbox"/> bow <input type="checkbox"/> stern <input type="checkbox"/> weather deck <input type="checkbox"/> catwalk <input type="checkbox"/> crosswalk <input type="checkbox"/> manifold area <input type="checkbox"/> gangway <input type="checkbox"/> tank <input type="checkbox"/> pumproom <input type="checkbox"/> crew quarters <input type="checkbox"/> engine space <input type="checkbox"/> steward spaces <input type="checkbox"/> freezer area <input type="checkbox"/> ladder <input type="checkbox"/> ashore <input type="checkbox"/> other						
If LADDER, specify location:						
If OTHER, specify location:						
Activity causing injury <input type="checkbox"/> altercation <input type="checkbox"/> assault <input type="checkbox"/> blasting <input type="checkbox"/> carrying objects <input type="checkbox"/> chipping/scaling <input type="checkbox"/> climbing <input type="checkbox"/> cutting <input type="checkbox"/> descending <input type="checkbox"/> driving <input type="checkbox"/> grinding <input type="checkbox"/> handling liquids/solids <input type="checkbox"/> jumping <input type="checkbox"/> lashing <input type="checkbox"/> line handling <input type="checkbox"/> lifting <input type="checkbox"/> operating machinery <input type="checkbox"/> pulling <input type="checkbox"/> pushing <input type="checkbox"/> routine work assignment <input type="checkbox"/> running <input type="checkbox"/> tank cleaning <input type="checkbox"/> using hand tools <input type="checkbox"/> walking <input type="checkbox"/> welding <input type="checkbox"/> other						
If "OTHER" accident, describe						
Vessel equipment involved (if none, write 'NONE')						
Type of accident <input type="checkbox"/> absorption <input type="checkbox"/> arc ray exposure <input type="checkbox"/> caught in/under/between objects or machinery <input type="checkbox"/> contact with electrical current <input type="checkbox"/> exposure to chemicals <input type="checkbox"/> exposure to temperature extremes <input type="checkbox"/> fall from elevation (unencumbered) <input type="checkbox"/> fall from elevation (encumbered) <input type="checkbox"/> fall on same level (unencumbered) <input type="checkbox"/> fall on same level (encumbered) <input type="checkbox"/> ingestion <input type="checkbox"/> inhalation <input type="checkbox"/> irritation <input type="checkbox"/> lifting/pulling/pushing exertion <input type="checkbox"/> rubbed or abraded <input type="checkbox"/> slip (no fall) <input type="checkbox"/> trip (no fall) <input type="checkbox"/> striking against <input type="checkbox"/> struck by <input type="checkbox"/> traffic <input type="checkbox"/> other						
If "OTHER" accident, describe						
If accident caused by the presence of a foreign substance, identify:				If OTHER substance, specify:		
Nature of illness/injury						
Supervisor (name)		Supervisor (rating)		Supervisor's signature		
Watch officer (name)		Watch officer (rating)		Watch officer's signature		
Reporting officer (name)		Reporting officer (rating)		Reporting officer's signature		
IF TREATMENT RECEIVED ASHORE, ATTACH COMPLETED REPORT OF ATTENDING DENTIST/PHYSICIAN						