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**REPORT OF PERSONAL INJURY OR LOSS OF LIFE**

- INSTRUCTIONS**
- An original of this form shall be submitted to the Maritime Administrator as soon after the occurrence of the casualty as possible.
  - This form must be completed in full. Entries which do not relate to a particular case should be indicated as not applicable by inserting the initials "N.A."
  - Please see reporting guidance in [MG-6-36-2](#).
  - This form should be completed by the Master or person in charge, or, if neither is available, by the owner or his duly authorized agent.
  - Attach crew list to this form. Attach separate Form [109-1](#) to this report for each person killed or injured and incapacitated in excess of 72 hours as a result of the vessel casualty reported herein.

**I. PARTICULARS OF VESSEL**

1. Name of Vessel	2. Official Number	3. Name and Address of Vessel's Manager, including Designated Person Ashore's Name, Email and Telephone Number
4. Type of Vessel (See Note 1.)	5. Propulsion (See Note 2.)	
6. Name of Owner		

**II. PARTICULARS OF PERSON INJURED, DECEASED OR MISSING**

7. (a) Name of Person: Surname: Given Name:	(b) Home Address  E-mail Address:	(c) Date of Birth  (d) Citizenship
8. Seafarer's Book or Passport No.	9. Status or Capacity on Vessel	
10. Activity Engaged in at Time of Casualty	11. If <input type="checkbox"/> Crew Member <input type="checkbox"/> Shore Worker <input type="checkbox"/> Passenger <input type="checkbox"/> On Watch <input type="checkbox"/> Working <input type="checkbox"/> Other	
12. (a) Name of Immediate Supervisor at Time of Casualty	(b) Supervisor's Capacity or Status on Vessel	

**III. PARTICULARS OF CASUALTY OR ACCIDENT**

13. (a) Date of Casualty	(b) Time (Local or UTC) <input type="checkbox"/> UTC <input type="checkbox"/> Local	(c) Time Zone Description	(d) Time of Day <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Twilight		
14. Location of Vessel at Time of Casualty (See Note 3.)			15. Name of Body of Water		
16. (a) If Casualty Occurred Underway, Port of Departure		(b) Date of Departure	(c) Port to Which Bound		(d) Est. Date of Arrival:
(e) Atmospheric Conditions <input type="checkbox"/> Clear/Partly Cloudy/Overcast <input type="checkbox"/> Fog <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Other:	(f) Visibility <input type="checkbox"/> Less than 1 NM distance <input type="checkbox"/> 1 - 2 NM <input type="checkbox"/> 2 - 5 NM <input type="checkbox"/> Over 5 NM	(g) Wind Force (Beaufort):  Direction:	(h) Sea <input type="checkbox"/> Calm <input type="checkbox"/> Moderate <input type="checkbox"/> Rough Wave Height:	(i) Swell Height:  Direction:	(j) Temperature Air:  Seawater:
17. (a) RESULT OF CASUALTY: <input type="checkbox"/> Injury <input type="checkbox"/> Death <input type="checkbox"/> Missing			(b) Location of Individual onboard		
(c) Nature of Injury			(d) Total Days Incapacitated (72 hours or more)		
(e) Medical Cause of Death			(f) Date of Death		

Note 1. Type of Vessel – General Cargo, Oil Tanker, Ore/Oil Carrier, Passenger, Bulk Carrier, Ore Carrier, Tug, etc.  
 Note 2. Propulsion – Steam Turbine, Turbo-Electric, Diesel, Diesel-Electric, etc.  
 Note 3. Location – If open sea, Latitude and Longitude; give distance to and name of nearest shore; if near coast give distance and true bearing to charted object; if in port, straits, river, channel, etc., give name.

18. WITNESSES TO ACCIDENT (At least two (2), if possible)			
Name Surname: Given Name:		Name Surname: Given Name:	
Address  E-mail Address:		Address  E-mail Address:	
Name Surname: Given Name:		Name Surname: Given Name:	
Address  E-mail Address:		Address  E-mail Address:	
19. (a) MEDICO (Medical) MESSAGE SENT	(b) IF YES, GIVE DATE OF FIRST MESSAGE	(C) IF YES, GIVE TIME OF FIRST MESSAGE (Local or zone and description)	
20. (a) TREATMENT ADMINISTERED <input type="checkbox"/> Yes <input type="checkbox"/> No	(b) IF YES, BY WHOM <input type="checkbox"/> Ship's Doctor <input type="checkbox"/> Other Ship's Personnel <input type="checkbox"/> Other (Specify)		
21. BRIEFLY DESCRIBE TREATMENT ADMINISTERED ONBOARD			
22. (a) Name of Hospital, if Person was Hospitalized		(b) Address of Hospital	
23. DESCRIPTION OF CASUALTY - Please describe what happened, including the sequence of events leading to the casualty. Attach diagram and additional sheets, if necessary.			
24. Vessel Operator's Investigation / Review <input type="checkbox"/> Not planned <input type="checkbox"/> In progress <input type="checkbox"/> Completed		Note: Completion of Blocks 25 and 26 is not necessary if the Operator's Investigation is either In Progress or Completed and will be provided to the <u>Maritime Administrator</u> .	
25. CAUSAL ANALYSIS / LESSONS LEARNED – Please describe why the casualty happened and lessons learned. Attach diagram and additional sheets, if necessary.			
26. CORRECTIVE / PREVENTATIVE ACTIONS – Please describe corrective actions taken after the incident and/or those that are planned to be taken in order to prevent similar incidents as well as any recommendations for the Maritime Administrator. Attach additional sheets if necessary.			
27. Date of Report	28. Submitted by (Print Name)	29. Signature	30. Title