



**OFFICE OF THE DEPUTY COMMISSIONER
OF MARITIME AFFAIRS, R.L.
LISCR, LLC**

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REPORT OF PERSONAL INJURY OR LOSS OF LIFE

INSTRUCTIONS

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| <p>1. An original of this form shall be submitted to the Maritime Administrator as soon after the occurrence of the casualty as possible.</p> <p>2. 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."</p> <p>3. Dates should be filled in as yyyy/mm/dd.</p> | <p>4. This form should be completed for every loss of life and for every injury which incapacitates the injured for a period in excess of seventy-two hours (3 days).</p> <p>5. 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.</p> |
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I. PARTICULARS OF VESSEL

1. Name of Vessel	2. Official Number	3. IMO Number
4. Type of Vessel (See Note 1.)	5. Propulsion (See Note 2.)	6. (a) Name, Address, Telephone and Email of Managing Agent / ISM Company
(b) Name of Owner		(c) Name, Address and Email of P&I Club

II. PARTICULARS OF PERSON INJURED, DECEASED OR MISSING (Believed dead)

7. (a) Name of Person	(b) Home Address	(c) Date of Birth
		(d) Citizenship
8. Seaman's Book or Passport No	9. Status or Capacity on Vessel	
10. Activity Engaged in at Time of Casualty	11. If Crew Member or Shore Worker <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 Zone)	(c) Zone Description	(d) Time of Day <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Twilight
14. Geographical Location of Vessel at time of Casualty (See Note 3.)			15. Geographical Name of Body of Water
16. (a) If Casualty occurred underway, Port of Departure		(b) Date of Departure	(c) Port to Which Bound
17. (a) RESULT OF CASUALTY: <input type="checkbox"/> Injury <input type="checkbox"/> Death <input type="checkbox"/> Missing (Complete INJURY or DEATH entries below, as appropriate.)			
(b) Nature of Injury			(c) Total Days Incapacitated
(d) Reason for Death			(e) Location of Individual at Death
			(f) Date of Death
(g) Has next of Kin been notified?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> When:			
By what means notified – explain:			

Note 1. Type of Vessel - General Cargo, Oil Tanker, Ore/Oil Carrier, Passenger, Bulk Carrier, Ore Carrier, Tug, etc.
 Note 2. Propulsion - Steam Reciprocating, Steam Turbine, Turbo-Electric; Diesel, 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. DESCRIPTION OF CASUALTY (Give events leading up to casualty and how it occurred. Attach diagram and additional sheets, if necessary.)

19. WITNESSES TO ACCIDENT (At least two, if possible)

Name	Name
Address	Address
Name	Name
Address	Address

IV. ASSISTANCE AND RECOMMENDATIONS

20. (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)
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21. (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)
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22. BRIEFLY DESCRIBE TREATMENT (If administered by other than M.D.)

23. (a) Name of Hospital, If Person was Hospitalized	(b) Address of Hospital
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24. Recommendations for Corrective Safety Measures Pertinent to this Casualty

25. Date of Report	26. Submitted by (Print Name)	27. Signature	28. Title
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