

## OCCUPATIONAL HEALTH INCIDENT FORM

This report is to be completed as a requirement of the Maritime Labour Convention (MLC), Regulation A4.3 – occupational accidents and injuries, and occupational diseases must be reported and investigated.

*Only submit reports if IP is off work for 3 days or more, or if hospitalised for at least 1 day.*

Please return a completed form for each individual affected and forward to:

**Maritime Affairs**

**OR**

**BAHAMAS MARITIME AUTHORITY**

[casualty@bahamasmaritime.com](mailto:casualty@bahamasmaritime.com)

**120 Old Broad Street**

**LONDON EC2N 1AR UK**

Name of Vessel:

IMO Number:

### Section A: Personal Details

Surname:

Given Name(s):

Gender:

Rank:

Nationality:

Age:

years

Record of hours of work or rest:

Hours in previous 72 hours:

Location of Incident

*(e.g. Lat/Long, name of port or other geographic reference):*

### Section B: Details of Incidents

Date:

Time (local):

Location on ship of incident:

Bodily location of injury:

Nature of injury:

Activity of seafarer at time of injury:

Witnesses:

Name:

Rank:

Name:

Rank:

Name:

Rank:

Outcome *(where known)*:

Brief description of events leading to the incident *(please use additional sheets if required)*:

**Section C: Environment**

Lighting				Weather			
Natural		Artificial		Sea State		Wind	
Light		Excellent		Sheltered waters		Calm	
Semi dark		Good		Calm		Breeze	
Dark		Poor		Moderate		Gale	
				Rough		Storm	

**Section D: Occupational Diseases**

Who diagnosed:

Type of Occupational Disease(s) (if known):

**Section E: Signed Declaration**

Are you Investigating Incident:

Is a Third Party Investigating:

Person completing form:

Name:

Position:

Signature:

not required if sending as e-form

Owners / Managers

Name:

Address:

Signed by Master:

not required if sending as e-form

Date:

Ships stamp

not required if sending as e-form