Revision Aug 2018

Name of Vessel / Facility_____

Supervisor's Incident Report Form

Entered into NS5 Quality & Compliance section as incident # _____

Title of incident _____

Name of Supervisor completing this report _____

This is a report of a: ☐ Near Miss ☐ First Aid Only ☐ Illness ☐ Chemical Exposure ☐ Initial Dr/ Hospital visit ☐ Follow up Dr/ Hospital visit ☐ Fatality ☐ Equipment Damage ☐ Equipment Failure ☐ Equipment Loss	
Date of incident: (DD-MONTH-YYYY)	Date of report: (DD-MONTH-YYYY)

Was employee working full or part time when incident occurred? _____

How long has employee been working this position? _____

Were TDI procedures/ PPE in place and used? _____ If not, why?

_____

What caused the event? _____

_____

If an injury/ injuries resulted, complete this section. If not, skip to next section.

Name of Injured Person _____(Circle one) Male Female

Date of Birth _____ Telephone Number _____

Address _____

City _____ State_____ Zip _____

What part of the body was injured? Describe in detail. _____

_____

What was the nature of the injury? Describe in detail. _____

_____

Was employee on or off shift, traveling to or from work site at time of injury?

_____

What equipment, chemicals, tools were being used by the employee?

_____

Please describe any first aid or medical treatment the employee may have received.

_____

Did injury occur because of:

_____Substance abuse _____ Failure to use safety devices/ PPE ____ Failure to follow procedures

Was International SOS contacted for advice about the illness/ injury? YES / NO No

(Continued on Next Page)

If yes, write the ISOS case number here: _____

If yes, enter the dates with approximate times of the calls and a quick summary of their advice.

1.

2.

3.

Was employee taken to a doctor's office for evaluation/ treatment? _____

Was employee treated in an Emergency Room? _____

Was employee hospitalized overnight as in-patient? _____

Name and Address of treating practitioner and hospital

_____

_____

_____

Was employee unable to work as a result of injury? _____ If yes, what was employee's first day unable to work? _____ Date of return to work?_____

If still off work, what is estimated date of return? _____

If the incident is related to equipment damage, failure or loss, complete this section.

List major equipment involved: _____

Did the equipment have any known defects/ damage before this event occurred? _____

If yes, describe: _____

_____

List any other possible contributing factors to the event- weather, employee experience/ training, off spec procedures, communications, etc. _____

_____

Was a new JSA required/ held to handle this incident? _____

How was the equipment repaired/ recovered? _____

_____

If not recovered, record the location of equipment here:

_____

If beacon was lost, record beacon serial # here:

Rented or owned by TDI? _____ Rented from whom?_____

Recommended action(s) to prevent future reoccurrence:

_____

_____ _____

Supervisor Signature **Date** (DD-MONTH-YYYY)