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| REPUBLIC OF VANUATU VANUATU MARITIME SERVICES, LTD PORT VILA, VANUATU | REPORT OF PERSONAL INJURY OR LOSS OF LIFE | FOR OFFICE USE ONLY |
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INSTRUCTIONS

1. This form shall be submitted to the Deputy Commissioner of Maritime Affairs as soon after the incident as possible.
2. This form must be completed in full. Entries which do not relate to the particular case should be indicated as "Not Applicable" by inserting the initials "NA".
3. 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).
4. This form must be completed by Master or person in charge, or, if neither is available, by the owner or his duly authorized agent.

I. PARTICULARS OF VESSEL

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| 1. NAME OF VESSEL | 2. OFFICIAL NUMBER |
| 3. NAME, ADDRESS, EMAIL AND TELEPHONE NUMBER OF MANAGING AGENT | |

II. PARTICULARS OF PERSON INJURED, DECEASED OR MISSING (BELIEVED DEAD)

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| 4. NAME AND HOME ADDRESS OF PERSON(IF MORE THAN ONE PERSON, MAKE OUT ONE FORM PER PERSON) | 5. DATE OF BIRTH |
| | 6. CITIZENSHIP |
| 7. VANUATU SEAMAN ID BOOK NUMBER AND/OR LICENCE NUMBER | 8. STATUS OR CAPACITY ON VESSEL |
| 9. ACTIVITY ENGAGED IN AT TIME OF CASUALTY | 10. IF CREW MEMBER PASSENGER OR SHORE WORKER |
| 11. NAME OF IMMEDIATE SUPERVISOR AT THE TIME OF CASUALTY | 12. SUPERVISOR'S CAPACITY ON VESSEL |

III. PARTICULARS OF INJURY OR DEATH INCIDENT

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|---|--------------------------|--|--|
| 13A. DATE OF INJURY OR DEATH | 13B. TIME(LOCAL OR ZONE) | 13C. ZONE DESCRIPTION | 13D. TIME OF DAY DAY NIGHT TWILIGHT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 14. GEOGRAPHICAL LOCATION OF VESSEL AT THE TIME OF INJURY OR DEATH * | | 15. GEOGRAPHICAL NAME OF BODY OF WATER | |
| 16A. IF INJURY OR DEATH OCCURRED UNDERWAY, PORT OF DEPARTURE | 16B. DATE OF DEPARTURE | 16C. PORT TO WHICH BOUND | |
| 17A. RESULT OF INCIDENT: <input type="checkbox"/> INJURY <input type="checkbox"/> DEATH <input type="checkbox"/> MISSING | | | |
| 17B. NATURE OF INJURY | 17C. DAYS INCAPACITATED | 17D. REASON FOR DEATH | |
| 17E. LOCATION OF INDIVIDUAL AT DEATH | 17F. DATE OF DEATH | | |

* Location – If at sea, latitude and longitude; if in port, straits, river channels, etc. give name.

Notification must be made immediately by the fastest means possible to the Deputy Commissioner of Maritime Affairs.
E-mail email@vanuatuships.com or fax 212-425-9652

18. DESCRIPTION OF INCIDENT LEADING TO INJURY OR DEATH. ATTACH DIAGRAMS AND ADDITIONAL SHEETS IF NECESSARY.

19. WITNESSES TO ACCIDENT: AT LEAST TWO, IF POSSIBLE.

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| 1. NAME | 3. NAME |
| ADDRESS | ADDRESS |
| 2. NAME | 4. NAME |
| ADDRESS | ADDRESS |

IV. ASSISTANCE AND RECOMMENDATION

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| 20A. MEDICO (MEDICAL) MESSAGE SENT <input type="checkbox"/> YES <input type="checkbox"/> NO | 20B. IF YES, GIVE DATE OF FIRST MESSAGE | 20C. IF YES, GIVE TIME OF FIRST MESSAGE (LOCAL OR ZONE AND DESCRIPTION) | |
| 21A. TREATMENT ADMINISTERED <input type="checkbox"/> YES <input type="checkbox"/> NO | 21B. IF YES, BY WHOM <input type="checkbox"/> SHIP'S DOCTOR <input type="checkbox"/> OTHER SHIPS PERSONNEL <input type="checkbox"/> OTHERS (SPECIFY) | | |
| 22(A) BRIEFLY DESCRIBE TREATMENT (IF ADMINISTERED BY OTHER THAN MD) | | | |
| 22(B) WHAT IS THE PROGNOSIS FOR RECOVERY? | | | |
| 23(A) IF INJURED PERSON WAS HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL. | | | |
| 23(B) IF INJURED PERSON WAS NOT HOSPITALIZED, WHEN WAS HE REPATRIATED? WHERE TO? | | | |
| 24. RECOMMENDATIONS FOR CORRECTIVE SAFETY MEASURES PERTINENT TO THIS INCIDENT. | | | |
| 34. DATE OF REPORT | 35. SUBMITTED BY (PRINT NAME) | 36. SIGNATURE | 37. TITLE |