KIRIBATI SHIP REGISTRY

Report of Personal Injury or Loss of Life

Instructions:

a) *An original of this form shall be submitted to the Flag State as soon as possible after the occurrence of the incident.*
b) *This form must be completed in full. Entries not relating to the case should be filled as N/A.*
c) *This form should be completed by the Master or supervisor, or if neither is available, by the owner or his duly authorized agent.*
d) *Crew list should be submitted together with this form. Attach an additional Form for each person injured or killed as a result of the incident reported herein.*

A. VESSEL PARTICULARS

Name of Ship (Block):	*Official Number:*	*Type of Ship:*

Name of Owner:

Name of Shipmanager:

Telephone:	*Facsimile:*	*Mobile:*	*Email:*

B. PARTICULARS OF THE INJURED, DECEASED OR MISSING

Name:	*Date of Birth:*	*Nationality:*	*Capacity on Vessel:*

Home Address:	*Activity Engaged in at Time of Incident / Casualty:*

Seaman Book or Passport No.:	*Name of Immediate Supervisor at Time of Incident / Casualty:*	*Supervisor's capacity or Status on vessel:*	*If Crew Member or Shore Worker*
			☐On Watch ☐Working ☐Other

C. DETAILS OF THE INCIDENT / CASUALTY

Date of Incident:	*Time of Incident (local or UTC):*	*Last Port of Departure:*	*Date of Departure:*

Location of Vessel at time of Incident (Port, country and coordinates):	*Port to which Bound:*	*Date of Expected Arrival:*

Geographical Name of Body of Water (at open sea):	*Result of Incident:*
	☐On Watch ☐Working ☐Others (specify): (Complete INJURY or DEATH entries below, as appropriate)

Nature of Injury (description of injury):	*Total Days Incapacitated (for injury):*

Cause of Death:	*Location of Individual at Death:*	*Date of Death:*

Description of Incident (Give events leading to the incident and how it occurred. Attach drawings and additional sheets, if required):			
Witness to the Incident			
Name (1):		*Address/ Contact (1):*	
Name (2):		*Address/ Contact (2):*	

D. ASSISTANCE RECEIVED & RECOMMENDATIONS

MEDICO (Medical) Message Sent:	*If Yes, Please state Date of First Message:*	*If Yes, Please state Time of First Message:*
☐No ☐Yes		

Treatment Administered:	*If Yes, By Whom:*
☐No ☐Yes	☐Ship's Doctor ☐Other Ship's Personnel ☐Others (specify)

Brief Description of Treatment Administered (If not administered by Medical Doctor):	
Name of Hospital (if hospitalized):	*Address of Hospital:*
Recommendations for Corrective Safety Measures Pertaining to this Incident:	

Date of Report:	*Name of Person Submitting:*	*Designation:*	*Signature:*