

Company: _____

ACCIDENT REPORT

NOTE : NOTIFY ALL ACCIDENTS IMMEDIATELY TO MANAGEMENT AND HSEQ MANAGER. ACCIDENT REPORT SHOULD BE COMPLETED WITHIN 24 HOURS AND SUBMITTED TO HSEQ MANAGER.

(1) GENERAL INFORMATION

| | | | | | |
|------------------------------------|---|-------|---------------------|---|--|
| Employee's Name | : | ..... | Employee's No. | : | ..... |
| Employment Date | : | ..... | Nationality | : | ..... |
| Occupation | : | ..... | Age | : | ..... |
| Hours on duty before accident | : | ..... | Sex | : | ..... |
| Date of First Lost Day | : | ..... | Driving Licence No. | : | ..... |
| Length of Time in Current Position | : | ..... | Purpose of Trip | : | ..... |
| Other passengers / Names | : | ..... | On company Business | : | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | : | | | : | |
| | : | | | : | |

(2) LOCATION OF INCIDENT

(3) DETAILED INFORMATION

| | | | | | |
|---------------------------------------|---|-------|---------|---|-------|
| Location | : | ..... | Country | : | ..... |
| Customer Name | : | ..... |  |  |  |
| Work Location (Rig, Lab, Vessel, Etc) | : | ..... |  |  |  |
| Time of Incident | : | ..... |  |  |  |
| Date of Incident | : | ..... |  |  |  |

| | | |
|-------------------------------|---|-------|
| Name of Duty Supervisor | : | ..... |
| Date Notified of Injury | : | ..... |
| Supervisor | : | ..... |
| Number of Days on Current Job | : | ..... |

(4) TYPE OF INJURY (CHOOSE PRIMARY INJURY)

(5) BODY PART INJURED (CHECK ALL THAT APPLY)

(6) PERSONAL PROTECTIVE EQUIPMENT UTILIZED

(7) INCIDENT TYPE (CHOOSE ONE)

| | | | |
|---|---|--|---|
| <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture <input type="checkbox"/> Bruise <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain-Strain <input type="checkbox"/> Foreign Body in Eye <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Dermatitis <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Thermal Contact Hot <input type="checkbox"/> Thermal Contact Cold <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Amputation <input type="checkbox"/> Occupational Illness (Specify Below) Other (Specify Below) If "other" or "Occupational Illness" Chosen, Specify Here : | <input type="checkbox"/> Head (Where?) <input type="checkbox"/> Face (Where?) <input type="checkbox"/> Eye <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Arm <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hand <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Abdomen <input type="checkbox"/> Groin <input type="checkbox"/> Finger (Specify) <input type="checkbox"/> Leg <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Ankle <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Toe (Specify) <input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Ear <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Multiple Body Parts | <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Head Protection <input type="checkbox"/> Safety Goggles <input type="checkbox"/> Coveralls <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Safety Belt <input type="checkbox"/> Chemical Apron <input type="checkbox"/> H2S Monitor <input type="checkbox"/> Gloves <input type="checkbox"/> Face Shield <input type="checkbox"/> Respirator <input type="checkbox"/> Breathing Apparatus <input type="checkbox"/> None Others : Estimated cost of property damage (.....) Recurrence Potential <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low Severity Potential <input type="checkbox"/> Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor | <input type="checkbox"/> Struck Against <input type="checkbox"/> Struck By <input type="checkbox"/> Fall – Different Level <input type="checkbox"/> Fall – Same Level <input type="checkbox"/> Slip – Twist <input type="checkbox"/> Over Exertion <input type="checkbox"/> Electrical Contact <input type="checkbox"/> Caught in-under-between <input type="checkbox"/> Extreme Temperature <input type="checkbox"/> Inhale – Absorb <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Bite – Sting <input type="checkbox"/> Burn <input type="checkbox"/> Using Hand Tools Other (Specify Below) If "other" or "Occupational Illness" Chosen, Specify Here : Manual Handling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|--|---|

| <u>(16) HAZARDOUS CONDITIONS</u> <u>(CHECK ALL THAT APPLY)</u> | <u>(17) UNSAFE ACTS</u> <u>(CHECK ALL THAT APPLY)</u> | <u>(18) CONTRIBUTORY CAUSES</u> <u>(CHECK ALL THAT APPLY)</u> |
|---|---|--|
| <input type="checkbox"/> Improperly Guarded Equipment or Machinery | <input type="checkbox"/> Operating without Authority | <input type="checkbox"/> Intoxication |
| <input type="checkbox"/> Defective Tool or Equipment | <input type="checkbox"/> Failure to Warn Others | <input type="checkbox"/> Inadequate Experience / Skill |
| <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Working at Unsafe Speed | <input type="checkbox"/> Inadequate Training / Knowledge |
| <input type="checkbox"/> Inadequate Lighting | <input type="checkbox"/> Bypassing Safety Devices | <input type="checkbox"/> Inadequate Procedures |
| <input type="checkbox"/> Inadequate Ventilation (Dust, Fumes, Etc.) | <input type="checkbox"/> Failure to Secure Objects | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Slippery or Unsafe Surface | <input type="checkbox"/> Using Unsafe Equipment or Equipment Unsafely | <input type="checkbox"/> Pre-existing Injury |
| <input type="checkbox"/> Inadequate Warning Systems | <input type="checkbox"/> Unsafe Loading, Lifting or Carrying | <input type="checkbox"/> Other : |
| <input type="checkbox"/> Hazardous Dress or Apparel | <input type="checkbox"/> Unsafe Position or Posture | ..... |
| <input type="checkbox"/> Work Procedures | <input type="checkbox"/> Unsafe Act of Another Person (Explain Below) | ..... |
| <input type="checkbox"/> Traffic | <input type="checkbox"/> Failure to Use Personal Protective Equipment Correctly | ..... |
| <input type="checkbox"/> Inadequate help for Heavy Lifting | <input type="checkbox"/> Failure to Observe Safety Requirements | ..... |
| <input type="checkbox"/> Hazardous Weather or Environment | <input type="checkbox"/> Disregard of Instructions | ..... |
| <input type="checkbox"/> Contact with Poisonous Plants, Inserts, Toxic Chemicals, Skin Irritants, Bites, Etc. | <input type="checkbox"/> Other : | |
| <input type="checkbox"/> Excessive Noise | | |
| <input type="checkbox"/> Other : | | |
| | | |
| | | |

(19) INVESTIGATION RESULTS

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On-Site Supervisor's Sign. : Name : Date :

(20) CORRECTIVE MEASURES

| What has been done or is planned to prevent recurrence of this incident? | 'T' = Action Taken 'P' = Action Planned | | If Planned | |
|--|--|----------------------------|-------------|---------------|
| | | | Assigned To | Required Date |
| Reinstruction of Person(s) Involved | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Secure Protective Equipment | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Improve Housekeeping | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Install Guards | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Correct Physical Conditions | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Improve Maintenance | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Improve Inspections | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Improve Design or Construction | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Assign Employee to Different Type of Work | <input type="checkbox"/> T | <input type="checkbox"/> P | | |
| Other | <input type="checkbox"/> T | <input type="checkbox"/> P | | |

Explain (Specify the Positive Corrective Action Taken to Prevent a Similar Incident in the Future):

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(21) ACKNOWLEDGMENT OF CORRECTIVE ACTIONS

Division Manager : Name : Date :

(22) JOB SAFETY ANALYSIS – SAFE JOB PROCEDURES

| | | |
|--|------------------------------|-----------------------------|
| Was there a Safe Job Procedure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Not, have Safe Job Procedures been Made? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If there was a Safe Job Procedure, was it Followed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have Safe Job Procedures been Reviewed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was a JSA / Risk Assessment Available at time of Incident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Last JSA / Risk Assessment Review / Revision : | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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HSE & Quality Manager

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Date