TUVALU SHIP REGISTRY

Report on Injury or Loss of Life

Tuvalu Ship Registry
10 Anson Road #25-16
International Plaza
Singapore 079903
Tel: (65) 6224 2345
Fax: (65) 6227 2345
Email: info@tvship.com
Website: www.tvship.com

NOTES

I. An original of this form shall be submitted to the Flag State as soon as possible after the occurrence of the incident.
II. This form must be completed in full. Entries not relating to the case should be filled as N/A.
III. This form should be completed by the Master or supervisor, or if neither is available, by the owner or his duly authorized agent.
IV. Crew list should be submitted together with this form.

VESSEL'S PARTICULARS		
Vessel Name	Official Number	Type of Vessel
Owner's Name		
Vessel Manager's Particulars (Include Name/ Address/ Telephone)		

PARTICULARS OF THE INJURED OR DECEASED			
Name	Date of Birth	Citizenship	Capacity on Vessel
Home Address	Seaman's Book or Passport No		
	Name of Immediate Supervisor at Time of Casualty		
Activity Engaged in at Time of Casualty	Supervisor's capacity or Status on vessel		
	If Crew Member or Shore Worker		
	☐On Watch ☐Working ☐Other		

PARTICULARS OF THE INCIDENT		
Date and Time of Incident	Last Port of Departure	Next Port of Arrival
Location of Vessel at time of Incident (Port, country or coordinates)		
	Date of Departure	Estimated Date of Arrival
Body of Water (if occurred at open sea)		

Result of Incident (Injury/ Death/ Missing), others please specify:		
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 additional sheets, if required)		

Witness to Accident			
Name (1)		Address/ Contact (1)	
Name (2)		Address/ Contact (2)	

DESCRIPTION OF ASSISTANCE RECEIVED	
Description Of MEDICO (Medical) Message Sent	
If YES please state date and time of first message	
Description of Treatment Administered	
If Yes, by Whom (Ship's Doctor/ Other crew) others, please specify:	
Name of Hospital (if hospitalized)	
Address of Hospital	
Recommendations for Corrective Safety Measures Pertaining to this Incident:	

Date of Report	Submitted by	Designation	Signature