



Maritime Helicopters

# FIRST REPORT of INJURY

Fax to the Quality & Safety Department as soon as possible. 907-452-4539

ACCIDENT DATA								
Base/Department:			SCHEDULE:		1	2	5&2	14&14
			(Check one box)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location: (Where injury occurred)		Date of Accident:	Time of Accident:	Date/Time Reported:	Time Employee Began Work:			
THE INJURED PERSON								
Name:		Date of Birth:	Age:	Home Address:				
Title:		Date of Hire:	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Marital Status:	Number of Children Under 18:	Social Security Number:		Home Phone:	Cell Phone:			
<b>TYPE of INJURY</b>		<input type="checkbox"/> Bruising		<input type="checkbox"/> Dislocation		<input type="checkbox"/> Other (specify)		Injured part of body:
<input type="checkbox"/> Strain/Sprain		<input type="checkbox"/> Scratch/Abrasion		<input type="checkbox"/> Internal		Remarks:		
<input type="checkbox"/> Fracture		<input type="checkbox"/> Amputation		<input type="checkbox"/> Foreign body				
<input type="checkbox"/> Laceration/cut		<input type="checkbox"/> Burn/Scald		<input type="checkbox"/> Chemical Reaction				
ACCIDENT SUMMARY (Use additional pages as necessary)								
Description: (Describe what happened. Include damage to any property and object or substance that inflicted damage)								
Witnesses: (List)								
Analysis: (Explain what caused of the accident)								
Prevention: (Recommend preventive measures and any corrective actions taken to date)								
SIGNATURES (By filling in your name below, you verify that you agree with the statements herein)								
Employee's Signature:		Date:	Supervisor's Signature:		Date:			
TREATMENT and INVESTIGATION of ACCIDENT (For office use only)								
Type of treatment:		Name of person giving first aid:		Doctor/Hospital:				
Accident investigated by:		Date:	Lost time:	Date returned to work:				

Fig: 2-1 First Report of Injury (page 1)

**CHECK THE BOX BESIDE EACH INJURED BODY PART  
NO MATTER HOW MINOR THE PROBLEM OR SYMPTOM IS.  
THEN INSERT AN "X" IN THE BOX THAT REPRESENTS THE DEGREE OF SEVERITY**

BODY PART	just											
	none		noticeable			moderate		severe		un-bearable		
	0	1	2	3	4	5	6	7	8	9	10	
A. Head	0	1	2	3	4	5	6	7	8	9	10	
B. Neck	0	1	2	3	4	5	6	7	8	9	10	
C. Abdomen	0	1	2	3	4	5	6	7	8	9	10	
D. Right Shoulder/ Upper Back/Chest	0	1	2	3	4	5	6	7	8	9	10	
E. Left Shoulder/ Upper Back/Chest	0	1	2	3	4	5	6	7	8	9	10	
F. Right Elbow	0	1	2	3	4	5	6	7	8	9	10	
G. Left Elbow	0	1	2	3	4	5	6	7	8	9	10	
H. Right Forearm	0	1	2	3	4	5	6	7	8	9	10	
I. Left Forearm	0	1	2	3	4	5	6	7	8	9	10	
J. Right Hand/Wrist	0	1	2	3	4	5	6	7	8	9	10	
K. Left Hand/Wrist	0	1	2	3	4	5	6	7	8	9	10	
L. Low Back	0	1	2	3	4	5	6	7	8	9	10	
M. Front Hips	0	1	2	3	4	5	6	7	8	9	10	
N. Buttocks	0	1	2	3	4	5	6	7	8	9	10	
O. Legs	0	1	2	3	4	5	6	7	8	9	10	
P. Feet	0	1	2	3	4	5	6	7	8	9	10	

Signature of Employee \_\_\_\_\_ Date of Occurrence \_\_\_\_\_

Print this chart on the back of Page 1. Complete as indicated, sign, and fax immediately to the Quality & Safety Department  
Have each witness complete the Witness Statement that is part of this packet.

Fig: 2-2 First Report of Injury (page 2)



**Maritime Helicopters ACCIDENT WITNESS STATEMENT**

Fax to the Quality & Safety Department as soon as possible (907-452-4539)

ACCIDENT DATA			
Injured Employee's Name:		Location of Accident:	
Name of Witness:		Date of Accident:	Time of Accident:
Job Title of Witness:		Home Address of Witness:	
Base/Department of Witness:			
<b>ACCIDENT SUMMARY (Use additional pages as necessary)</b>			
<b>Description:</b> (Describe in detail all events actually witnessed)			
<b>Observation:</b> (Describe bodily injury observed by witness. Be specific about body part(s) affected)			
<b>Witnesses:</b> (List all other possible witnesses)			
<b>Prevention:</b> (Recommend preventive measures and any corrective actions)			
<b>SIGNATURES (By filling in your name below, you verify that you agree with the statements herein)</b>			
Employee's Signature:	Date:	Supervisor's Signature:	Date:

Fig: 2-3 Accident Witness Statement



**SUPERVISOR'S ACCIDENT INVESTIGATION**

Fax to the Quality & Safety Department as soon as possible (907-452-4539)

ACCIDENT DATA			
Location where accident occurred:		Company Property: <input type="checkbox"/> Yes <input type="checkbox"/> No Customer Property: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident:
Name of injured employee:		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee	Time of Accident:
Job title of employee:	Name of base / department normally assigned to:	How long has employee worked at job where injury occurred?	Employee's normal starting time:
List property that was damaged:		Damaged property owned by:	
ACCIDENT SUMMARY (Use additional pages as necessary)			
What was employee doing when injury / illness occurred? What machine or tool was involved? What operation was being performed?			
How did injury / illness occur? List all objects and substances involved:			
Part of body affected:		Any prior physical defects? If so, specify what: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature and extent of injury/illness and property damaged (be specific):			
CONTRIBUTING FACTORS (Please indicate all of the following that contributed to the injury or illness.):			
<input type="checkbox"/> Improper instruction	<input type="checkbox"/> Failure to lockout	<input type="checkbox"/> Unsafe arrangement or process	
<input type="checkbox"/> Lack of training or skill	<input type="checkbox"/> Unsafe position	<input type="checkbox"/> Poor ventilation	
<input type="checkbox"/> Operating without authority	<input type="checkbox"/> Improper dress	<input type="checkbox"/> Improper guarding	
<input type="checkbox"/> Horseplay	<input type="checkbox"/> Improper protective equipment	<input type="checkbox"/> Improper maintenance	
<input type="checkbox"/> Physical or mental impairment	<input type="checkbox"/> Unsafe equipment	<input type="checkbox"/> Inoperative safety device	
<input type="checkbox"/> Failure to secure	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Other:	
CORRECTIVE ACTIONS			
List corrective action(s) have you taken to insure that this type of accident does not reoccur.		√	By Whom:
		<input type="checkbox"/>	When:
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
Was employee retrained in the appropriate use of PPE and/or proper safety procedures?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was employee cautioned for failure to use PPE and/or proper safety procedures?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
SIGNATURES (By filling in your name below, you verify that you agree with the statements herein.)			
Supervisor's Name (print):		Supervisor's Signature:	Date:

Fig: 2-4 Supervisor's Accident Investigation