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| **CONFIDENTIAL**  Mandatory to complete form for Cority data entry by the Houston Health Service when an   * actual or suspected injury or illness occurs at work * injury or illness is attributed to work.   Optional when entered into Cority by site Medic. If you have questions, please contact your Petroleum Deepwater (WEL) HSE Business Partner (BP).  **Email this form to**  Health@petroleumdeepwater.com  DO NOT attach this form to the Event Mgmt Solution (EMS) as it contains personal information.  A contract company or external practitioner form may be used, provided it contains all of the information outlined in this form. |

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| PART A: MANDATORY TO BE COMPLETED BY THE INJURED/ ILL PERSON (IP) or SUPERVISOR IF IP UNABLE | | | | | | | | |
| **Injured/Ill Person (IP) Details** | | | | | | | | |
| IP First & Last Name: | Click or tap here to enter text. | | | Gender: | | Male  Female | |
| Worker Type: | Pet DW (WEL) Employee full time  Pet DW (WEL) Employee part time  Contractor  Visitor | | | | **For Contractor / Visitor** | | |
| IP Date of Birth | | Click or tap to enter a date. |
| Company / Organization: | | Click or tap here to enter text. |
| Start & End Dates: | | Click or tap here to enter text. |
| IP Phone: | Click or tap here to enter text. | | | IP Email: | | Click or tap here to enter text. | |
| Pet DW (WEL) Supervisor Name: | Click or tap here to enter text. | | | Pet DW (WEL) Supervisor Email: | | Click or tap here to enter text. | |
| Department: | Click or tap here to enter text. | | | Location: | | Click or tap here to enter text. | |
| Job Title: | Click or tap here to enter text. | | | Work Schedule  *(eg 10h M-Th 0700-1730):* | |  | |
| Event Details | | | | | | | | |
| Chief Complaint - Detail injury/illness include all body parts & problem  *(e.g., laceration to right hand, or lower back pain):* | | | | Click or tap here to enter text. | | | | |
| Event Date: | Click or tap to enter a date. | | | Event Time: | | am  pm | |
| Physical Location | APU  GOMPU  TTPU  Projects | | WSD  E&A  Houston Office  Closed sites | Specific event location  Click or tap here to enter text. | | | |
| Time shift started  *(on event day):* | Choose an item. | | | Time shift ended  *(on event day):* | | Choose an item. | |
| Hours into Shift  *(on event date):* | Click or tap here to enter text. | | | Days into swing  *(on event date):* | | Click or tap here to enter text. | |
| Date Reported: | Click or tap to enter a date. | | | Time Reported: | | am  pm | |
| Describe how the injury/illness occurred, including what, where when and how? | | | | Click or tap here to enter text. | | | | |
| What was the IP doing just before the injury/illness occurred? | | | | Click or tap here to enter text. | | | | |
| Was an object or substance involved? | | | | Yes – if yes specify Click or tap here to enter text.  No | | | | |
| Is this a new injury/illness? | | | | Yes  No – if no provide details of pre-existing condition Click or tap here to enter text. | | | | |
| Did you miss time from work due to the injury/illness? | | | | Yes – if yes date/s of first lost time: Click or tap here to enter text.  Date the IP returned to work: Click or tap to enter a date.  No | | | | |
| **Treatment Details** | | | | | | | | |
| Treatment was/will be provided for this injury/illness? *(including first aid or self-treatment)* | | | | | | | | |
| No treatment - *report only*  Yes – *provide details* | | |  | | --- | | List treatment(s): Click or tap here to enter text. | | Date/Time of treatment: Click or tap here to enter text. | | If accompanied, person’s name: Click or tap here to enter text. | | Name of treatment provider: Click or tap here to enter text. | | Treatment provider’s phone: Click or tap here to enter text. | | | | | | |
| **Signature** | | | | | | | | |
| I, the injured/ill person, herein certify the information above is true and correct to the best of my knowledge. | | | | | | | | |
| Signature (Injured/Ill Person): | | | | | | | Date: Click or tap to enter a date. | |

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| **MANDATORY TO BE COMPLETED BY WEL HSE SPECIALITIES TEAM** | | | |
| Event Type | Work Related Injury\*  Work Related Illness\*  Non-Work Related Condition  \**event will automatically be created in the EMS once entered into Cority.* | OSHA Classification | Report Only  First Aid  Medical Treatment  Restricted Work  Lost Time |
| If Work Related Illness- specify type 1SAP illness type | Cancer, Tumor or Neoplasm  Poisoning and Toxic Effects  Noise Induced Hearing Loss  Dermatitis or Eczema  Infectious and Parasitic Diseases  Musculoskeletal Occ Illness  Silicosis  COPD & Asthma  Other Respiratory System Disease  Other Disease or Disorder | WEL Risk Actual Severity Level | No Treatment  Low level Impact Resulting in First Aid  Non-Life Altering or Short-Term Injury or Illness  Life Altering or Long Term /Permanent Injury or Illness  Fatality |
| Injury/Illness Classification Justification | Click or tap here to enter text. | | |
| Mechanism of injury | Click or tap here to enter text. | | |
| Additional Comments | Click or tap here to enter text. | | |
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| PART B: MANDATORY TO BE COMPLETED BY ALL WITNESSES | | | | |
| **Witness Details** | | | | |
| Witness First & Last Name: | Click or tap here to enter text. | | | |
| Worker Type: | Pet DW (WEL) Employee full time  Pet DW (WEL) Employee part time  Contractor  Visitor |  | | |
| Witness Phone: | Click or tap here to enter text. | Witness Email: | Click or tap here to enter text. | |
| Pet DW (WEL) Supervisor Name: | Click or tap here to enter text. | Pet DW (WEL) Supervisor Email: | Click or tap here to enter text. | |
| Department: | Click or tap here to enter text. | Location: | Click or tap here to enter text. | |
| Job Title: | Click or tap here to enter text. | Work Schedule  *(e.g., 10h M-Th 0700-1730):* | Click or tap here to enter text. | |
| Witness Statement | | | | |
| Event Date: | Click or tap to enter a date. | Event Time: | Enter Time.  am  pm | |
| Describe in as much detail as possible how this event occurred - what, where when and how?  Click or tap here to enter text. | | | | |
| **Signature** | | | | |
| I, the witness, herein certify the information above is true and correct to the best of my knowledge. | | | | |
| Witness Signature: Click or tap here to enter text. | | | | Date: Enter Date |

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| **Note:** If initially, first aid is rendered but at a later date further treatment is required, please notify  your facility Medic or email the details to Health@petroleumdeepwater.com.  Seeking first aid treatment and completion of this report does not waive the injured/ill person’s right to file a  workers’ compensation claim and seek benefits in accordance with statutory workers’ compensation laws. |