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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.comDO 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*  |

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| 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. |

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| **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. |