



**EMPLOYEE'S REPORT
OF MARITIME
INJURY OR ILLNESS**
[see reverse side for guidance]
AMHS TRACKING # [_____]

Distribution:
Original to ADOA-Risk Management
Copy to Ward N. America, Inc.
Copy to AMHS Personnel
Copy to Vessel
Copy to Master (Weekly Report)

I. EMPLOYEE DATA:

Union: _____ [] MM&P [] IBU [] MEBA
Social Security No.: _____
Name: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Telephone No.: (____) _____ - _____ Date of Birth: ____/____/____ [] Male [] Female
Occupation: _____ Department Employed In: [] Purser [] Steward [] Deck [] Engineering
Supervisor: _____ Wages: \$ _____ Per [] Hour [] Month
Work Week Began: ____/____/____ End: ____/____/____ Shift Began: _____ AM/PM
[] Employee an assigned crew member [] Employee assigned as a Relief [] Employee onboard as a passenger

II. EMPLOYEE'S DESCRIPTION OF [] INJURY or [] ILLNESS ⇔ Check one [In Employee's own words/handwriting]

Date & Time Injury/Illness Occurred: Date: ____/____/____ Time: ____ AM/PM
Date & Time Left Work: Date: ____/____/____ Time: ____ AM/PM [] Did Not Leave Work
Date & Time Returned to Work: Date: ____/____/____ Time: ____ AM/PM
Location: [] Vessel Name: [_____] [] Other Location: _____
Where, onboard, did the Injury/Illness occur? _____
How did it happen and what work (activity) was being done at the time? _____

Describe the nature of Injury/Illness: _____

Did you seek or receive medical treatment onboard the vessel? [] YES [] NO
Are you planning to, or did you, seek medical care off the vessel? [] YES [] NO
Name & Address of Physician who is treating you for this injury/illness: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Was Employee Hospitalized? [] YES [] NO Hospital: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Was the accident caused by failure of a machine, a substance, or an object? [] YES [] NO

Name the Machine, Substance, or Object which injured the employee:

[_____]

If accident was caused by anyone besides the employee - give name & address: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

III. WITNESS(es): [NOTE: If more space needed, attach separate sheet] [] No Witness

Name: _____ Address: _____ [] Crew Member [] Passenger

IV. PAYMENT OPTION:
[Check either Illness or Injury]

For Illness: [] Pay maintenance only. [] Pay sick leave instead of maintenance.
[] If sick leave exhausted - pay vacation/annual leave instead of maintenance, but if
vacation/annual leave exhausted - pay maintenance.
For Injury: [] Pay maintenance only. [] Pay maintenance plus sick leave to equal daily wage.
[] If sick leave exhausted - pay maintenance plus vacation/annual leave to equal daily wage.

V. SIGNATURES:

Employee's Signature: _____ Date: ____/____/____ Time: _____ AM/PM

Reported To: _____ Date: ____/____/____ Time: _____ AM/PM

Investigated By: _____ Date: ____/____/____

Vessel Master: _____

Date: ____/____/____

EMPLOYEE'S REPORT OF MARITIME INJURY OR ILLNESS

The following instructions are guidelines for completing this report [Form 25M-018, rev 12/98]. **You must ensure all pertinent data/information blocks are completed and remember to give as much detail as possible.** The majority of the form is self explanatory - however, the following is guidance for certain blocks (data-fields): If more space is needed, attach additional paper and ensure it (1) references this particular injury/illness; and (2) is signed and dated.

I. EMPLOYEE DATA BOX: ✍

AMHS Tracking # .. This number is assigned by AMHS Personnel Office [leave blank].
Union Check the appropriate one or write the commonly used acronym for the employee's union, or spell it out.
Name Vessel employee's first, middle initial, and last name(s).
SSN Give employee's Social Security Number.
Physical Address Give full address. *Cannot be a P.O. Box, must be a physical (e.g. Street) address.*
Mailing Address If it is the same as Physical Address just write the word "SAME"
Telephone No. Give the individual's home number, not their work number.
DOB Give employee's Date of Birth.
M or F Check whether employee is Male or Female.
Occupation Write the position/title of the employee (e.g. Steward, A/B, Jr. Engineer, etc).
Department Write name of the Department the employee is with (e.g. Deck, Steward, Engineering, etc.)
Supervisor Give the name and title of the employee's Supervisor.
Wages Self explanatory. Check if per HOUR or per MONTH.
Workweek Began/End Give the date: the employee's work week **began**, and was scheduled to **end**.
Shift began Employee's watch, e.g. 0600-1200 (use 24 hour clock times).
Employee onboard Check the one that accurately describes why the employee was onboard.

II. EMPLOYEE'S DESCRIPTION OF INJURY OR ILLNESS BOX: ✍

NOTES: (1.) **This section must be in the Employee's own words & handwriting.** If not, the reason it isn't must be stated and the name of the individual filling it out must be indicated on this form or an attached sheet.
(2.) If more space is needed, for any portion, attach an additional sheet that is signed and dated by the employee.
(3.) Check either the INJURY box or the ILLNESS box.

Dates Self explanatory. **All dates are to be mm/dd/yy, e.g. 07/15/98 = July 15, 1998.**
Locations..... (*) If Vessel - check box and write the name of vessel. (*) If Other - write the exact location of the injury/illness. (*) Attach diagrams and/or photographs - as appropriate.
Where, Onboard..... Write in the exact location onboard the Vessel the injury occurred or where the illness began (onset). Attach Diagrams and/or Photographs as appropriate.
How / What..... Give as much detail as possible to fully describe how it happened, and fully describe what work was being done at the time of the injury or onset of the illness. **Do not write normal/routine duties.**
Nature..... Fully describe exact nature of the injury or illness. Medical terminology is not mandatory. Also, briefly-but fully-describe part of the body that was injured or affected by the injury/illness, including which side (e.g. left arm, right leg, and so forth).
Medical Treatments: ONBOARD: If the employee sought or received medical treatment for their injury or illness onboard, check the appropriate box.
ESLEWHERE: If the employee did or is planning to seek medical treatment off the vessel, check the appropriate box.
Physician..... Give the name & address of physician that has or is treating the employee concerning this injury/illness.
Hospitalized..... Check appropriate box; and if hospitalized, give name and address of hospital.
Machinery; If employee believes the injury or illness was or was not caused by the failure of a piece of machinery, object, or substance onboard the Vessel; check the appropriate box; Substance; and if applicable - briefly describe what caused it. If unknown or employee is unavailable, Or Object: write "UNKNOWN" or "EMPLOYEE UNAVAILABLE."
Other Cause..... If injury/illness was caused by anyone besides the employee, give requested information.

III. **WITNESS:** Give full name and address of witnesses, and check whether they're a crew member or passenger.

IV. **PAYMENT:** The appropriate box, in either Illness or Injury, must be checked by the employee. The adjuster will contact the employee to determine whether they wish to proceed with Maintenance & Cure remedy or want to receive amount equal to Worker's Compensation instead of maritime remedies. Contact AMHS Personnel for complete details.

V. SIGNATURE BOXES:

- (1.) Employee just signs in their space. **Signatures are required for each individual listed!**
- (2.) The "Reported To" individual - - is the first crew member (normally the employee's supervisor) the employee reported the injury/illness to.
- (3.) For the "Reported to", "Investigated by", and " Vessel Master" please print or type the individuals name, include title/position, and then have them sign above it - prior to submittal.
- (4.) The Employee & Reported To individual must include the time (use 24 hour clock times) of their signature.

IMPORTANT NOTE: If any of the signers has additional information to add or disagrees with what the employee states, attach a signed and dated statement from/for each signer.

DISTRIBUTION OF COPIES: Self explanatory [see distribution box – upper right-hand corner].

 **REMEMBER, AS REQUIRED, SUBMIT A “FIT / UNFIT FOR DUTY” FORM - - PROMPTLY !**