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| **Notification of accidents etc. in relation to offshore oil and gas activities etc. (**Executive Order No. 1196 of 9 October 2015 on Registration and Reporting of Accidents etc. relating to offshore oil and gas operations etc.) |
|  |

**1. Injured person**

|  |  |  |
| --- | --- | --- |
| Name | | Social security number (CPR-nr.) |
| Address | Postal code | City |
| Job title on the time of accident | | Country |
| Date of recruitment | | Income for the year before the accident |

**2. Employer of the injured person on the time of the accident**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of the company | | CVR-number/P-number | |
| Address | Postal code | City | Phone |
| Name of installation or vessel where the accident happened | | | |
| Insurance company of the employer ( only to be filled in when the employer notifies) | | Policy number | |

**3. Time/place of the accident**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Year | Month | Day | Hour | Minute | State as accurate as possible where on the installation the accident happened: | |
| Shift started at: | | | | Offshore experience/seniority | | Start date of the offshore period |

**4. Sequence of events**

|  |  |
| --- | --- |
| What kind of work did the injured person perform? | What instrument, machine, or tool did the injured person use? |
| Sequence of events (Preferably attach additional supplements) | |

**5. How did the accident happen (Mode of injury)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Contact with electricity |  | Fire and explosions |  | Other, state here: |
|  | Collision with stationary object |  | Falling or stumbling |  | |
|  | Hit by object in motion |  | In contact with chemicals |
|  | Acute overload of body/part of body |  | Exposed to radiation |
|  | Contact with sharp, point, or rough object |  | Excess pressure, decompression |
|  | Drowned, or exposed to other lacks of oxygen |  | Squeezed or crushed |

**6. Internal investigation of the accident**

|  |
| --- |
| Have there, due to the accident, been taken any immediate precautions to prevent similar accidents? If yes, which?  (Preferably attach additional supplements) |

**7. Information about the injury**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of injury (one cross, only)** | | **Injured part of the body (one cross, only)** | |
|  | Wounds and superficial injuries |  | Head |
|  | Bone fracture |  | Neck, e.g. cervical vertebra |
|  | Dislocation, sprain, or strain |  | Back, e.g. vertebra |
|  | Concussion, or other internal injuries |  | Body and organs |
|  | Burn, scald, or congelation |  | Limbs of the upper part of the body |
|  | Poisoning or infection |  | Limbs of the lower part of the body |
|  | Drowning or choking |  | Entire body or multiple body parts |
|  | Injuries due to noise, vibrations, or pressure |  | Other injury, state here: |
|  | Injuries due to high temperatures, radiation or light |  | |
|  | Shock |
|  | Corrosive burn |
|  | Loss of one or multiple body parts (traumatic amputation) |
|  | Hypothermia (low body temperature) |
|  | Other (state description below) |
| Describe the damage further: | | | |

**8. Consequences of the injury**

|  |  |  |  |
| --- | --- | --- | --- |
| For how long is the injured person expected to be incapacitated? | | | |
|  | Incapacitated less than 1 day |  | Incapacitated 5 weeks-6 months |
|  | Incapacitated 1-3 days |  | Incapacitated more than 6 months or permanently. |
|  | Incapacitated 4-14 days |  | Dead |
|  | Incapacitated more than 14 days-5 weeks | State, if possible, the actual number of days of incapacity: | |

**9. Notification under the Workers’ Compensation Act**

|  |  |  |  |
| --- | --- | --- | --- |
| Is the accident being notified as a case of industrial injury to the insurance company of the employer /the Labour Market Insurance with regard to a review under the Workers’ Compensation Act? | Yes |  | **If yes**, please send a copy to the insurance company. |
| No |  |

**10. Witnesses, if any**

|  |  |
| --- | --- |
| Name: | Address: |
| Name: | Address: |

**11. Information about the notifier**

|  |  |  |  |
| --- | --- | --- | --- |
| The notifier is: | | Stamp, phone and person of contact: | Date (day, month, year): |
|  | Employer |
|  | Doctor/dentist | Signature of the notifier |
|  | Injured person |
|  | Medic |
|  | Other |