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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**

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| 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**

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| --- |
| 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 |