NAOERO
MARITIME ADMINISTRATION

Report on Personal Injury or Loss of Life
(Form NMA-15_PI.2026.Rev.1)

Instructions:	
1. An original of this form shall be submitted to the Flag State as soon as possible after the occurrence of the incident. 2. This form must be completed in full. Entries not relating to the case should be filled as N/A.	3. This form should be completed by the Master or supervisor, or if neither is available, by the owner or his duly authorised agent. 4. Crew list should be submitted together with this form. Attach an additional Form NPI for each person injured or killed as a result of the incident reported herein.

1. VESSEL PARTICULARS

Vessel Name	Official Number	Type of Vessel

Name of Owner

Name of Shipmanager

Telephone	Facsimile	Mobile	Email

2. PARTICULARS OF THE INJURED, DECEASED OR MISSING

Name	Date of Birth	Nationality	Capacity on Vessel

Home Address	Seaman Book or Passport No
	Name of Immediate Supervisor at Time of Incident / Casualty
Activity Engaged in at Time of Incident / Casualty	Supervisor's capacity or Status on vessel
	If Crew Member or Shore Worker □On Watch □Working □Other

3. DETAILS OF THE INCIDENT / CASUALTY

Date of Incident	Time of Incident (local or UTC)	Last Port of Departure	Date of Departure
Location of Vessel at time of Incident (Port, country and coordinates)		Port to which Bound	Date of Expected Arriva
Geographical Name of Body of Water (at open sea)			

Result of Incident □On Watch □Working □Others (specify): (Complete INJURY or DEATH entries below, as appropriate)			
Nature of Injury (description of injury)			Total Days Incapacitated (for injury)
Cause of Death	Location of Individual at Death		Date of Death
Description of Incident (Give events leading to the incident and how it occurred. Attach drawings and additional sheets, if required)			
Witnesses to the Incident			
Name (1)		Address/ Contact (1)	
Name (2)		Address/ Contact (2)	

4. ASSISTANCE RECEIVED & RECOMMENDATIONS		
MEDICO (Medical) Message Sent □No □Yes	If Yes, Please state Date of First Message	If Yes, Please state Time of First Message
Treatment Administered □No □Yes	If Yes, By Whom □Ship's Doctor □Other Ship's Personnel □Others (specify)	
Brief Description of Treatment Administered (if not administered by Medical Doctor)		
Name of Hospital (if hospitalised)		
Address of Hospital		
Recommendations for Corrective Safety Measures Pertaining to this Incident:		

Date of Report	Name of Person Submitting	Designation	Signature