Oil & Gas Development Company Limited

Register of Occupational Illnesses and Injuries

This is OSHA-Compliant Monitoring System Document.

Location: _____ Month _____ Year _____

IDENTIFY THE PERSON			***DESCRIBE THE CASE***			***CLASSIFY THE CASE*** *Check only one box for each case based on the most serious outcome for that case*				***ENTER THE NUMBER OF DAYS the injured or ill worker was:***		***CHECK THE "INJURY" COLUMN OR CHOOSE ONE TYPE OF ILLNESS:***														
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)														
Case No.	**Employee's Name & Employee No.**	**Job Title** (e.g. *Welder*)	**Date of injury or onset of illness**	**Where the event occurred** (e.g. *Mechanical Workshop*)	**Describe injury or illness, parts of body affected, and object / substance that directly injured or made person ill** (e.g. *Second degree burns on left forearm from acetylene torch*)	**Death**	**Days away from work**	**Remained at work**		**Away from work**	**On job transfer or restriction**	Injury	Hearing Loss (Noise Induced)	Eye disorders (Light Related)	Musculoskeletal Disorder	Skin related diseases	Gastrointestinal	Respiratory	Cardiovascular	Diabetes	Malaria	ENT	Dental	Genitourinary	Others
								Job transfer or restriction	**Other recordable cases**																	
						☐	☐	☐	☐	____ days	____ days															
						☐	☐	☐	☐	____ days	____ days															
						☐	☐	☐	☐	____ days	____ days															

Filled, Checked & Verified (Stamped) by Field Medical Representative: _____ Date: _____