



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 <i>Check only one box for each case based on the most serious outcome for that case</i>				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) Remained at work		(K)	(L)	(M)													
Case No.	Employee's Name & Employee No.	Job Title <i>(e.g. Welder)</i>	Date of injury or onset of illness	Where the event occurred <i>(e.g. Mechanical Workshop)</i>	Describe injury or illness, parts of body affected, and object / substance that directly injured or made person ill <i>(e.g. Second degree burns on left forearm from acetylene torch)</i>	Death	Days away from work	Job transfer or restriction	Other recordable cases	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
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ days	_____ days														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ days	_____ days														
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ days	_____ days														

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