

Appendix 2

INJURY REPORT FORM HAZARD ALERT

Reported by: Name: _____ Staff No.: _____ Country/Port: _____

Dept: _____ Report Date: _____ Phone No.: _____ Level of Involvement Directly Involved
 Witness
 3rd Party Reporter

Other Personnel/Witnesses

<input type="checkbox"/> Name: _____ Staff No.: _____ Contact No.: _____ E-Mail: _____ <input type="checkbox"/> Involved <input type="checkbox"/> Witness	<input type="checkbox"/> Name: _____ Staff No.: _____ Contact No.: _____ E-Mail: _____ <input type="checkbox"/> Involved <input type="checkbox"/> Witness
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Date of Occurrence: DD / MM / YY Time of Occurrence: HH / MM Location of Occurrence: _____

Action Taken

On-site first aid given by _____ Specify Aid Given: _____
 Ambulance requested Hospitalisation required
 Medical Assistance sought at medical clinic Cleared for duty Prescribed sick leave _____ Days
 Other action taken, specify: _____

Mechanism of Injury (how it happened)

- | | |
|--|--|
| <input type="checkbox"/> Collision with object | <input type="checkbox"/> Slip / Trip / Fall |
| <input type="checkbox"/> Struck by falling object | <input type="checkbox"/> Chemical exposure |
| <input type="checkbox"/> Struck by moving object | <input type="checkbox"/> Lift / Carry |
| <input type="checkbox"/> Heat / Friction | <input type="checkbox"/> Twist / Shear |
| <input type="checkbox"/> Electricity | <input type="checkbox"/> Crush / Trap / Entangle |
| <input type="checkbox"/> Glass / Needle / Sharp object | |
| <input type="checkbox"/> Others, specify: _____ | |

Nature of Injury

- | | |
|--|--|
| <input type="checkbox"/> Bruise / Contusion | <input type="checkbox"/> Burn |
| <input type="checkbox"/> Graze / Abrasion | <input type="checkbox"/> Strain / Sprain |
| <input type="checkbox"/> Cut / Laceration | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Puncture / Penetration / Stab | <input type="checkbox"/> Electric |
| <input type="checkbox"/> Shock <input type="checkbox"/> Fracture | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Others, specify: _____ | |

Part of Body Injured (tick all that apply)

- | | | | |
|--|---|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Head / Skull | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Mouth / Teeth | <input type="checkbox"/> Back | <input type="checkbox"/> Fingers | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand / Palm | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Trunk | <input type="checkbox"/> Wrist | <input type="checkbox"/> Calf |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Stomach | <input type="checkbox"/> Forearm | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Pelvis / Groin | <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Face | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Upperarm | |
- L / R
Side of Body
(Please Circle)

Equipment / Instrument involved

- | | |
|---|---|
| <input type="checkbox"/> Baggage | <input type="checkbox"/> Hot Food / Beverage |
| <input type="checkbox"/> Cart / Trolley | <input type="checkbox"/> Floor |
| <input type="checkbox"/> Service Equipment | <input type="checkbox"/> Wet surface |
| <input type="checkbox"/> Doors | <input type="checkbox"/> Travelator |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Others, specify: _____ |
| <input type="checkbox"/> Wheelchair | |
| <input type="checkbox"/> Electrical Appliance | |

Is there a prior medical history of this problem? No Yes, specify _____

Details of the Incident / Actions – Please use additional sheets if required. (Please print clearly)

PROPOSED PREVENTATIVE ACTION (To prevent a future similar event)

I declare that the information given in this statement is, to the best of my knowledge, true and accurate.

Name (in block letters): _____ Signature: _____

Date: _____ ERN: _____

Please read the Medical Information Collection Statement and complete the below if the incident occurred in the course of employment.

Medical Information Collection Statement

Any medical records or information collected pursuant to this consent will be kept in strict confidence and will only be used by such persons designated by the Company and who are directly involved in the administration of the staff member's absences and Jardine Lloyd Thompson Ltd. ("JLT"), for the purposes of assessing the reported incident in relation to any possible requirements and eligibility under applicable legislation including the Employees' Compensation Ordinance. In addition, such information may also be used by the Company for purposes relating to his or her employment to which such information is relevant, including assessment of his or her medical condition (if any) as it impacts upon and relates to his or her fitness to fulfil inherent job duties or requirements and consideration for workplace accommodation and/or rehabilitative support. If the staff member does not provide consent to the disclosure of such relevant records and information to the Company or JLT, and refuses to otherwise provide such records and information to the Company or JLT, the Company will not be able to make the necessary assessment of his or her condition, and may have to make such assessment without the information. Based on limited information, the Company may not be able to provide appropriate, if any, workplace accommodation and/or rehabilitative support. Medical records and information released to the Company will be kept on the staff member's personal file maintained by the Company. The staff member has a right to request a copy of such information and/or correction of the information by contacting People Department, in accordance with the Company's Personal Data Access Guidelines. Any medical records or data which the staff member or his or her treating doctor(s) submit to the Company pursuant to this consent will be destroyed three years after the cessation of the staff member's employment, except where there is then an ongoing or possible dispute to which the records or data may be related, in which case such records or data will be held until the dispute is completed or concluded.

Points to Note: The information supplied on this form shall form the basis of the Company's report of an accident to the Labour Department under the provisions of the Employees' Compensation Ordinance.

I, _____ (HKID No. _____) hereby authorize and grant consent to Jardine Lloyd Thompson Ltd. ("JLT"), acting as agent for my employer, Cathay Pacific Airways Limited, to (1) obtain, inspect and /or review all medical information, including medical reports, notes and records, as may be considered relevant and necessary by the examining doctor or such other medically trained person as may be designated by my employer and JLT, in connection with my medical condition and any examination, consultation and treatment pertaining to my injury; and (2) disclose the same and my personal data as defined in section 2 of the Personal Data (Privacy) Ordinance, Cap. 486 to my employer and /or any of its appointed medical examiners and laboratories to make an assessment of my medical condition for the purpose of providing appropriate workplace accommodation and/or rehabilitative support, and to the Labour Department to make an assessment or application of my eligible compensation under the Employees' Compensation Ordinance. A copy of this authorization shall be as effective and valid as the original of it.

Signature: _____ (Name in Block Letters: _____) GalaCXy ID: _____
Date: _____

(For HKIA staff) Designated AMSC: _____

Direct Appraiser/Supervisor/Manager-On-Duty acknowledgement: Witnessed injury? Yes No

Name: _____ Position: _____ GalaCXy ID: _____ Contact Tel.: _____

Signature: _____ Date: _____

Brief description/ any other comment regarding the incident:

HONG KONG DRAGON AIRLINES LIMITED
CABIN CREW WORK-RELATED ACCIDENT OCCURRENCE REPORT

PART 1

Case No: _____
(For office use only)

A. Statement

I declare that the information given below in this form is true, correct and complete to the best of my knowledge. I understand that making false and misleading statement in this report is a serious offence and may lead to disciplinary action including but not limited to summary dismissal.

Signature: _____ Rank: _____ Working Position Onboard the Flight: FA (_____)
Full Name: _____ (ERN: _____) Date: _____

Notes about Personal Data

- a) The personal data provided by means of this form will be used by the Personnel Department for the purpose of processing work-related injury case in compliance with the requirements under the Employees' Compensation Ordinance (Cap. 282) or any other related issues.
- b) The personal data provided in this form may be disclosed to other authorized Company staff, approved medical specialists, the Labour Department and/or other authorized party to process the case.
- c) The data subject has the right of access and correction with respect to personal data as provided for in Section 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance (Cap. 486).
- d) Enquiries concerning the personal data collected by means of this form, including the making of access and correction should be addressed to the Personnel Department, Hong Kong Dragon Airlines Limited.

B. Essential Information of the Accident

Date of the accident: _____ (dd/mm/yy) Time of the accident: _____ (am/pm)

Place of the accident: _____

The accident occurred in the aircraft
Flight No: KA _____ A/C Reg _____
Route from: _____ to _____

The accident occurred in other place
Please specify: _____
(e.g. Office building/ Hotel/Airport/ En-route, etc)

If the accident occurred in the aircraft, please state:

(1) The exact location:
 Aerobridge
 Galley (Front /Mid/Aft) Pax seat no: _____ Toilet no: _____
 Cabin near row _____ Others (Please specify) _____

(2) The phase of flight:
 On ground Taxiing Climbing Cruising Descending

(3) Were any tools, equipment or materials being used when the accident occurred?
 No Yes, please specify below
 Beverage trolley, no: _____ Food cart, no: _____
 Coffee/ teapot Oven/ slid
 Pax baggage at seat no: _____ Crew baggage
 Armrest Overhead locker Seat back/ table Others: _____ of seat no: _____
 Others (Please specify) _____



(4) Describe in details how and why the accident occurred (Please use supplementary paper/s if required).

Describe immediate corrective actions you /other appropriate person have/ has taken to prevent further injuries (can choose more than one)

No treatment Bandage Oxygen Cold compress
 Burnt cream Ointment Elevation Others (Please Specify) _____

C. Nature of Injury

(1) Part of body injured:

<u>Head</u>	<u>Neck & Trunk</u>	<u>Upper Limbs</u>	<u>Lower Limbs</u>
<input type="checkbox"/> Skull/Scalp	<input type="checkbox"/> Neck (L/R/B)	<input type="checkbox"/> Finger (L/R/B)	<input type="checkbox"/> Hip (L/R/B)
<input type="checkbox"/> Eye (L/R/B)	<input type="checkbox"/> Back (L/R/B/U/Lo)	<input type="checkbox"/> Hand/Palm (L/R/B)	<input type="checkbox"/> Thigh (L/R/B/U/Lo)
<input type="checkbox"/> Ear (L/R/B)	<input type="checkbox"/> Chest (L/R/B)	<input type="checkbox"/> Wrist (L/R/B)	<input type="checkbox"/> Knee (L/R/B/U/Lo)
<input type="checkbox"/> Mouth/Tooth	<input type="checkbox"/> Abdomen (L/R/B/U/Lo)	<input type="checkbox"/> Forearm (L/R/B/U/Lo)	<input type="checkbox"/> Leg (L/R/B/U/Lo)
<input type="checkbox"/> Nose	<input type="checkbox"/> Trunk (U/Lo)	<input type="checkbox"/> Elbow (L/R/B)	<input type="checkbox"/> Ankle (L/R/B)
<input type="checkbox"/> Face (L/R/B)	<input type="checkbox"/> Pelvis/Groin (L/R/B)	<input type="checkbox"/> Arm (L/R/B/U/Lo)	<input type="checkbox"/> Foot (L/R/B)
		<input type="checkbox"/> Shoulder (L/R/B)	<input type="checkbox"/> Toe/s (L/R/B)

Others/ Multiple parts (Please specify): _____

L—Left, R—Right, B—Both, U—Upper, Lo—Lower

(2) Nature:

Abrasion 擦傷 Amputation 切斷 Burn 燒傷/灼傷 Contusion 瘀傷/挫傷

Laceration & Cut 撕破/割傷 Sprain & Strain 扭傷/拉傷

Others (Please Specify): _____

D. Endorsement by FA1 / Cabin Crew Department Representative:

Signature: _____ Date: _____

Full Name: _____ (ERN: _____) Rank: _____

Remarks

- a) This report should be completed by injured crew and passed to FA1 immediately.
- b) FA1 should endorse and return the completed form (Part I, III & IV) to Cabin Crew Department within 3 calendar days after the accident.

Pink copy: To be returned to Cabin Crew Department.

White copy: To be kept by injured crew for presentation at medical examination within 5 calendar days after the accident.

(SHA-Based Crew) To be kept by injured crew for own record.

Consent Form (B)

This is kept by injured crew & please present during Initial Medical Examination

Instructions for Cabin Crew:

1. Complete both **Consent Form (A)** and **Consent Form (B)**
2. Injured crew submits Consent Form (A) together with **Pink Copy** of Cabin Crew Work-Related Accident Occurrence Report Part I to ISD Cabin Crew Personnel Team
3. Hong Kong based crew should attend medical examination in Hong Kong at one of designated clinics listed below **within 5 days upon arrival** in Hong Kong, and pass the **White Copy** of Cabin Crew Work-Related Accident Occurrence Report Part I and **Consent Form (B)** to the examining doctor.

Consent:

I acknowledge that by signing the Declaration below, I hereby authorize and grant consent to my employer, Hong Kong Dragon Airlines Limited ("Dragonair") and Jardine Lloyd Thompson Ltd. ("JLT"), acting as agent for my employer, to obtain, inspect and/or review all medical information, including medical reports, notes and records, as may be considered relevant and necessary by the examining doctor or such other medically trained person as may be designated by my employer and JLT, in connection with my medical condition and any examination, consultation and treatment pertaining to my injury. I also authorize Dragonair and JLT to disclose the same and my personal data as defined in section 2 of the Personal Data (Privacy) Ordinance, Cap. 486 to: one another's designated persons handling my case; to any of its appointed medical examiners and laboratories to make an assessment of my medical condition for the purpose of providing appropriate workplace accommodation and/or rehabilitative support; and to the Labour Department to make an assessment or make an application or appointment to assess my eligibility for compensation under the Employees' Compensation Ordinance, Cap. 282. A copy of this authorization shall be as effective and valid as the original of it.

DECLARATION:

I, _____ (HKID No. _____) have read this Consent Form (B). I understand that by signing this Consent Form, I agree to the Consent stated above of this Consent Form. I also believe that the facts stated on this Consent Form are true.

Date of accident: _____ Name in Block Letters: _____ ERN: _____

Signature: _____ Date: _____

Details of the Designated Work Injury Clinics for initial medical examination – BY APPOINTMENT ONLY.
Information below is for reference only. We advise you to contact the clinic for the most updated information.

Consultation Doctor	Address	Phone number	Consultation Hours
Dr. To Dinh Bau Dr. Joseph Yao CENTRAL	6/F., Crawford House, 70 Queen's Road Central, Central, Hong Kong	2868 9009	Monday to Friday 10:00 am - 1:00 pm 3:00 pm - 6:00 pm Saturday 10:00 am - 1:00 pm Sunday & Public Holiday Closed
Dr. Rosalind Yong Hun Yue MONGKOK	Room 501, Mong Kok Commercial Centre, 16 Argyle Street, Mongkok, Kowloon	2396 3011	Monday to Friday 9:30 am - 1:00 pm 3:30 pm - 7:00pm Saturday 9:30 am - 1:00 pm Sunday & Public Holiday Closed
Evergreen Medical Centre TSUEN WAN	Shop C5, 2nd Floor, Tsuen Fung Shopping Centre, 168 Sai Lau Kok Road, Tsuen Wan, N.T.	2414 4881	Monday, Wednesday, Thursday 9:00 am - 12:30pm 3:00 pm - 7:00 pm Tuesday and Friday 3:00 pm - 7:00 pm Saturday 10:00 am - 12:30pm 3:00 pm - 4:30pm Sunday & Public Holiday Closed
Dr. Chow Ho Ming SHATIN	Shop 4A, G/F, Hilton Plaza, Shatin, N.T.	2601 3730	Monday to Friday 9:00 am - 1:00 pm 3:30 pm - 7:30 pm Saturday 9:00 am - 1:00 pm Sunday & Public Holiday Closed
A.D.E.C. Medical Alliance TUEN MUN	Room 2312, Tuen Mun Parklane Square, 2 Tuen Hi Road, Tuen Mun, N.T.	2458 8222	Monday to Saturday 9:30 am - 1:00 pm 3:00 pm - 6:00 pm 8:30 pm - 10:00 pm Sunday & Public Holiday 9:30 am - 1:00 pm 3:00 pm - 6:00 pm
Raffles Medical Centre - HK Airport AIRPORT	6T - 009, Level 6, Terminal 1, HK Int'l Airport, Chek Lap Kok, N.T.	2261 2626	Daily 7:00 am - 12:00 am

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