REPORT OF MISHAP INSTRUCTIONS

For mishaps causing injury or illness to more than one individual, complete and attach a DS-1663 *(with only sections 1-19 completed)* for each additional individual.

I. MISHAP INFORMATION

1. Agency - Agency of injured individual or agency reporting damaged property.

2. Post/City, ST - Provide post name for overseas mishaps, US City and State for domestic mishaps.

3. Organizational Symbol - For domestic mishaps only, provide office symbol of injured individual or office reporting damaged property.

4. Type of Mishap - Check one or more types that apply to this mishap. For "Environmental Contamination," see NOTE.

5. Date of Mishap - Enter the date of mishap as mm-dd-yyyy. For illnesses *(e.g., cumulative trauma)*, enter the date of diagnosis or onset of disability, whichever is earlier.

6. Time of Mishap - Enter time as hh:mm. Check a.m. or p.m.

7. Location of Mishap - Check all the appropriate boxes that apply for property type and ownership of USG facility or residence. Then briefly describe the specific location on the property *(e.g., warehouse, swimming pool, cafeteria, office area, bedroom)*.

8. Detailed Description of Mishap - Describe in as much detail as possible, the who, what, where, when, why and how of the mishap. Include relevant remarks about weather, equipment or tools involved, unsafe conditions, acts and personal factors and whether other persons may have contributed to the accident. For environmental mishaps, describe the failures *(equipment or personnel)* that led to the release of chemicals or pollutants.

II. PERSONAL INFORMATION

9. Name of Individual - Self Explanatory. Check the "TDY" box if employee was on a temporary duty assignment when the mishap occurred.

10. Sex - Self Explanatory.

11. Date of Birth - Enter date of injured individual's birth as mm-dd-yyyy.

12. Category and Job/Activity - For employees, check one personnel category and provide the injured employee's job title or a brief job description. *(FS - Foreign Service, GS - General Service, FSN - Foreign Service National, EFM - Eligible Family Member, PSC - Personal Services Contractor, CON - Contractor. For Other - enter brief description (e.g., family member, local national)*). Check the "Post-Managed Contractor?" box if the contractor is being managed by Post personnel, versus OBO personnel on an OBO-managed project.

III. INJURY/ILLNESS INFORMATION

13. Severity of Injury or Illness - Check all that apply. For "Fatal", "Permanent Disability", see NOTE. For "Lost time/Restricted Duty, enter the number of days in block 17. "Medical Attention Other than First Aid" are mishaps that do NOT result in lost time from work, but where medical treatment is administered by a physician or registered professional personnel under the orders of a physician. First Aid treatment *(i.e., one-time treatment of minor scratches, cuts, burns, splinters and so forth)* does not ordinarily require medical care, even if administered by a physician or registered professional.

14. Fatality - Enter date of death if after date of mishap as mm-dd-yyyy.

15. Medical Attention - Inpatient hospitalization means being admitted to the hospital for at least one overnight stay resulting from the injury/illness. For "Emergency Room" medical care, check for any instances where the patient used emergency room services.

16. Cause of Mishap - Identify the event that resulted in the injury or illness *(such as falling from, struck by, lifting, inhaling)* and the object or source involved *(such as ladder, tool, chemical)*. For property damage or environmental contamination, provide the event and source leading to the damage/contamination.

17. Nature of Injury or Illness - Indicate the type of injury *(or property damage)* or illness, such as 2nd degree burn, fracture, abrasion, contusion, amputation, hearing loss, irritation, cancer, liver disease, contamination, etc.

18. Body Part(s) Injured - Indicate the body parts(s) injured, such as lower arm, ankle, ribs, neck, head, eye, hearing, liver, respiratory tract, etc. *(Leave blank for property damage mishaps)*.

19. WORK-RELATED EMPLOYEE INJURIES ONLY

a. Estimated Calendar Days Lost from work - A count of all calendar days (consecutive or not), including weekend days and holidays, after, but not including, the day of injury or illness onset, where the employee would have worked but could not because of the injury or illness.

b. Estimated Days Restricted Duty - The number of days when the employee could not perform any or all of his or her normal assignment during all or any part of the workday or shift, because of the injury or illness.

c. Name of treating physician/health care provider - Self Explanatory

d. Treatment facility name and address *(if off-site)* - Self Explanatory

e. Employee's Date of Hire - Enter the date as mm-dd-yyyy.

f. Employee's Shift Start Time - Enter as hh:mm.

IV. PROPERTY DAMAGE INFORMATION

20. Estimated Amount of Property Damage - Self Explanatory. Leave blank for injury/illness mishaps.

21. Type of Property - Such as building, residence, GOV, POV, personal property, security barrier, etc.

22. Property Status - Check if property is government owned.

V. CORRECTIVE ACTION

23. What Corrective Action Has Been or Will Be Implemented - Describe action(s) to be taken that will prevent the recurrence of similar mishaps in the future. Indicate whether actions have been implemented, or estimated date of when actions will be implemented.

VI. SUPERVISOR/POSHO INFORMATION

Signatures - The POSHO must review and sign off on the DS-1663.

FILING INSTRUCTIONS

Overseas

Send the completed form to the Post Occupational Safety and Health Officer (POSHO) at your Post. If that's not possible, scan and email a copy to OBO/OPS/SHEM at:
SHEM-MRSAdmin@state.gov

Domestic

Director, DESD (A/OPR/FMS/DESD)
2201 C Street, NW
Washington, DC 20522-6011
or by Fax to 202-647-1873

Workers' Compensation Claim Filing - Do **NOT** send CA-1 or CA-2 forms to OBO/OPS/SHEM. Employees need to file claims electronically using the Department of Labor's ECOMP system. Contact HR/ER/WLD for additional information:
Workers' Compensation Program

NOTE: The following categories of mishaps must be reported within 12 hours as per 15 FAM 964.4-1:

* Injury or occupational illness resulting in a fatality, permanent total disability or inpatient hospitalization;
* Property damage of $50,000 or more;
* Operations curtailed or shut down for more than 8 hours;
* Injuries or occupational illnesses *(with lost workdays)*, involving three or more employees;
* Any environmental contamination.

PRIVACY ACT STATEMENT

AUTHORITY: The Occupational Safety and Health Act of 1970 (29 U.S.C. 657, 673); Secretary of Labor's Order No. 12-71 (36 FR 8754), 8-76 (441 FR 25059), or 9-83 (48 FT 35736) and Code of Federal Regulations, Occupational Safety and Health Administration, Labor (29 1904, 1-22).

A Report of Mishap (15 FAM 964) is required whenever a mishap occurs on Department-owned or -leased property, or during the conduct of U.S. Government business. Reporting is required when mishaps result in personal injury or illness, property damage, or environmental contamination.

PURPOSE: The principal purpose of the Report of Mishap is to inform safety and health officials of all occupational injuries, illnesses, official vehicle collisions, property damage, and environmental contamination incidents. Sufficient details must be provided to ensure appropriate corrective actions are developed and implemented to help prevent future occurrences. It is also used to ensure that supervisors are aware of their safety/health responsibilities.

ROUTINE USES: These reports are used to provide injury and illness data to the Department of Labor in the Department's Safety and Occupational Health Annual Report. This report is designed to document and measure the progress of the safety program. Mishap reports are reviewed during program assessments and to focus training/assistance efforts on the information contained therein.

COMPLETE THIS FORM TO REPORT ALL MISHAPS RESULTING IN INJURIES, INCLUDING INJURIES FROM OFFICIAL VEHICLE MISHAPS, ILLNESSES, OR ENVIRONMENTAL CONTAMINATION

U.S. Department of State

REPORT OF MISHAP

I. MISHAP INFORMATION

1. Agency	2. Post/City, State	3. Organizational Symbol

4. Type of Mishap *(Check all that apply)*

☐ Illness/Injury ☐ Property Damage ☐ Environmental Contamination

5. Date of Mishap *(mm-dd-yyyy)*	6. Time of Mishap *(hh:mm)*	☐ a.m. ☐ p.m.

7. Location of Mishap *(Check all that apply)*

a. Type: ☐ USG Facility ☐ USG Residence ☐ Other _____

b. Ownership: ☐ Gov. Owned/Capital Lease ☐ Operating Lease ☐ LQA

Specific Location _____

8. Detailed Description of Mishap/Property Damage *(please attach Form DS-1664 if Motor Vehicle)*

II. PERSONAL INFORMATION

9. Name of Individual *(Last, First, MI.)* ☐ TDY

10. Sex *(Check one)*	11. Date of Birth *(mm-dd-yyyy)*
☐ Male ☐ Female	

12. Category *(Check one)*

☐ PSC ☐ CON ☐ FS ☐ EFM ☐ GS ☐ Other _____ ☐ FSN

Job/Activity _____ ☐ Post-managed Contractor?

III. INJURY/ILLNESS INFORMATION

13. Severity of Injury or Illness *(Check all that apply)*

☐ Fatal ☐ Permanent Disability ☐ Lost Time/ Restricted Duty ☐ First Aid ☐ Medical Attention *(Other than First Aid)*

14. Fatal - Date of Death *(if after date of mishap - mm-dd-yyyy)*

15. Medical Attention

☐ Inpatient Hospitalization ☐ Emergency Room

16. Cause of Mishap

17. Nature of Injury or Illness *(contusion, laceration, sprain, fracture, muscle strain, etc.)*

18. Body Part(s) Injured

19. WORK-RELATED EMPLOYEE INJURIES ONLY:

a. Calendar Days Lost _____ b. Days Restricted Duty _____

c. Name of treating physician/health care provider _____

d. Treatment facility name and address *(if off-site)*

e. Employee's Date of Hire *(mm-dd-yyyy)* _____

f. Employee's Shift Start Time *(hh:mm)* _____ ☐ a.m. ☐ p.m.

IV. PROPERTY DAMAGE INFORMATION

20. Est Amount of Property Damage	21. Type of Property	22. Property Status
		☐ USG owned

V. CORRECTIVE ACTION

23. Describe recommended action(s) that will prevent the recurrence of a similar mishap in the future, and whether or when these actions have been implemented.

VI. SUPERVISOR/POSHO INFORMATION

Supervisor's Name		POSHO's Name and Title	
Supervisor's Signature	Date *(mm-dd-yyyy)*	POSHO's Signature	Date *(mm-dd-yyyy)*

DS-1663
05-2018