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Treatment of the Conscious Diver

- Assess for life threatening or other severe injuries?
- Assess if the diver is alert and oriented
- Is the incident diving related?
- Remove exposure suit and keep diver dry and warm
- Hydrate with appropriate fluids
- Place in position of comfort
- Take and record vitals q 15 min or as needed
- Contact medical control or EMS
- Monitor patient closely

Call 911 or alternate emergency response

Initiate oxygen therapy

Perform neuro exam
Treatment of the Unconscious Diver

- Assess if the diver is breathing
- Check pulse and if needed begin CPR
- Remove exposure suit and keep diver dry and warm
- Is the incident diving related?
- Place in lateral recumbent position
- Initiate advanced care to level of training (IV, airway, etc)
- Take and record vitals q 5 min
- Monitor patient closely

Call 911 or alternate emergency response

Apply AED

Initiate oxygen therapy

Is the incident diving related?
Sign and Symptoms of DCS

Type I DCS

Musculoskeletal
- Discomfort or abnormal feeling in or near a joint.
- Constant aching pain, usually not tender to touch or movement.
- No outward change in appearance

Skin
- Itching
- Rash
- Localized swelling of the skin
- Marbling (patchy blue and pink areas) – Cutis Marmorata – Not simple skin bends and may require treatment

Lymphatic
- Swelling of extremity
- Pain in the area of swelling
Type II DCS

Neurologic
- Headache
- Numbness or tingling
- Weakness or paralysis
- Nausea
- Loss of bowel or bladder control
- Extreme fatigue
- Visual disturbances
- Difficulty standing or walking
- Chest pain
- Shortness of breath
- Behavioral changes
- Feeling of something’s wrong

Vestibular (inner ear)
- Hearing loss
- Tinnitus (ringing in the ears)
- Vertigo
- Nausea/vomiting
- Lack of coordination

Pulmonary
- Chest tightness
- Difficulty breathing
- Chest pain
- Rapid breathing
- Abnormal breath sounds
Signs and Symptoms of AGE

Symptoms occur at or near the surface or generally within 10 minutes of surfacing

- Extreme fatigue
- Difficulty in thinking
- Vertigo
- Nausea and/or vomiting
- Hearing abnormalities
- Bloody sputum
- Loss of control of bodily functions
- Tremors
- Loss of coordination
- Loss of consciousness
- Cardiopulmonary arrest
- Other stroke like symptoms
Oxygen Toxicity

- Visual disturbances
- Ears (ringing, extraneous noises)
- Nausea
- Twitching/Tingling
- Irritability
- Dizziness
- Convulsions
NOAA DIVER CONTACT INFORMATION

Name of Diver: _____________________________ DOB: ____________
Present Address: _____________________________ Zip: ____________
Height: _________ Weight: _________   Age: ________    M ____  F ____
Home Phone: ______________ Work: ____________ Cell: ____________
Present Employer: ____________________________________________
Significant Medical History / Allergies: _____________________________

Preferred contacts in event of an emergency:
Name:_________________________________ Phone: _______________
Name:_________________________________ Phone: _______________

DIVE HISTORY

Date: ______ Time of Day: _______ Depth: _______ Bottom Time: ______
Breathing Gas: ________________ Equipment Used: ________________
Did anything unusual occur prior to or during dive?  If so, describe
____________________________________________________________
If repetitive, list specifics of previous dives in past 24 hours:
Depth: _________ Bottom Time: _________ Surface Interval: __________
Depth: _________ Bottom Time: _________ Surface Interval: __________
Depth: _________ Bottom Time: _________ Surface Interval: __________
Depth: _________ Bottom Time: _________ Surface Interval: __________
Location at time of injury: ___________________________ Time of onset: _________
Was symptom noticed before, during, or after the dive? ________________
If during, was it while descending, on the bottom, or ascending? ________
Has symptom increased or decreased since first noticed? ________________
Diver’s description of symptoms (include location, type, quality, etc.)

____________________________________________________________
ADDITIONAL DIVE HISTORY

Does pain radiate? If so, where from ___________________ to ___________________

Does pain increase with movement or palpation? ______________________________

Have any other symptoms occurred since the first one was noticed? If so, describe ___
_____________________________________________________________________

Has patient ever had a similar symptom? If so, describe _________________________
_____________________________________________________________________

Has patient ever had DCS or AGE before? If so, note when and describe: __________
_____________________________________________________________________

Dive Buddy’s comments: _________________________________________________
_____________________________________________________________________
_____________________________________________________________________

ADDITIONAL BACKGROUND INFORMATION

Does the patient smoke? _____ yes or ____ no

Has there been any recent exposure to altitude? _____ yes or ____ no

Are there any dive-related problems that could explain the present symptoms? ______
_____________________________________________________________________

Current medication list: ___________________________________________________________________

List all medications taken during the previous 24-hours _________________________
_____________________________________________________________________

If the diver is female, when was her last menstrual cycle? _______________________

When did the diver last eat and drink? ________________________________

Describe the activities performed during the dive: ____________________________
_____________________________________________________________________

Describe the activities performed following the dive: _________________________
_____________________________________________________________________

_____________________________________________________________________

09/24/2015 (2)
NOAA NEUROLOGIC EXAM FOR DIVING CASUALTIES

Name: ________________________________________________________________  Date/Time: _____________________

Describe symptom: ______________________________________________________________________________________
______________________________________________________________________________________________________

Dive Profile: D/BT _____ / ___ SI ____ min D/BT _____ / ___ SI _____ min D/BT ____ / _____ SI ____ min D/BT ____ /_____

MENTAL STATUS/STATE OF CONSCIOUSNESS

(Circle one)
A = Awake and alert  Knows:  person ___  place ___  time___  year ___ Identify objects? ______
V = Responsive to voice  Can add nickel, quarter, and dime? ____ Glasgow Coma Scale score: ______
P = Responsive to pain  Recite 3 unrelated objects after wait? _____
U = Unresponsive  Speech: ___ normal   ___ abnormal

VITAL SIGNS  Pulse/min _____  Respirations _____  Blood Pressure ______  Temp (warm, cool, normal)

COORDINATION  (Normal/Abnormal)

Walk: __________
Heel-to-toe: __________
Romberg: __________
Finger-to-nose: __________
Heel-shin slide: __________
Rapid movement: __________

STRENGTH

Graded 0-5:
0 = Paralysis (no motion possible)
1 = Profound weakness (trace of muscle contraction)
2 = Severe weakness (muscle contraction but not against gravity)
3 = Moderate weakness (can overcome gravity but not resistance)
4 = Mild weakness (able to resist slight force)
5 = Normal (equal strength, able to resist force)

COORDINATION  (Normal/Abnormal)

Sense of smell (I) __________
Vision/visual field (II) __________
Eye movements, pupils (III, IV, VI) __________
Facial sensation, chewing (V) __________
Facial expression muscles (VII) __________
Hearing (VIII) __________
Upper mouth, throat sensation (IX) __________
Gag and voice (X) __________
Shoulder shrug (XI) __________
Tongue (XII) __________

CRANIAL NERVES  (Normal/Abnormal)

Upper body:  Deltoids:  L _____ R ______
Latissimus:  L _____ R ______
Biceps:  L _____ R ______
Triceps:  L _____ R ______
Forearms (grip):  L _____ R _____
Lower body:  Hips - Flexion:  L _____ R ______
Extension:  L _____ R ______
Knees - Flexion:  L _____ R ______
Extension:  L _____ R ______
Ankles - Dorsi/extension:  L _____ R _____
Plantarflexion:  L _____ R ______

REFLEXES

Grade: (0-absent, 1-hypoactive, 2-normal, 3-hyperactive)

Biceps:  L _____ R ______
Forearm:  L _____ R ______
Knees:  L _____ R ______
Ankles:  L _____ R ______

EXISTING MEDICATIONS:

DESCRIBE ALL ABNORMAL FINDINGS:
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Verbal Response</th>
<th>Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneously 4</td>
<td>Talking/Oriented 5</td>
<td>Obey commands 6</td>
</tr>
<tr>
<td>To verbal command 3</td>
<td>Confused/Disoriented 4</td>
<td>Localizes to pain 5</td>
</tr>
<tr>
<td>To painful stimulus 2</td>
<td>Inappropriate words 3</td>
<td>Withdraws from pain 4</td>
</tr>
<tr>
<td>None 1</td>
<td>Incomprehensible words 2</td>
<td>Abnormal Flexion 3</td>
</tr>
<tr>
<td></td>
<td>None 1</td>
<td>Abnormal extension 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None 1</td>
</tr>
</tbody>
</table>

09/24/2015 (2)
SENSORY EXAMINATION FOR SKIN SENSATION
(Check for sharp, dull, light touch sensation; use diagram to record location of numbness/tingling, pain)

LOCATION

Comments: ___________________________________________________________ ______________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Examiner (print)                              Signature                                       Title                             Date

09/24/2015 (2)
GLASGOW COMA SCALE

I. Motor Response
   6 - Obeys commands fully
   5 - Localizes to noxious stimuli
   4 - Withdraws from noxious stimuli
   3 - Abnormal flexion, i.e. decorticate posturing
   2 - Extensor response, i.e. decerebrate posturing
   1 - No response

II. Verbal Response
   5 - Alert and Oriented
   4 - Confused, yet coherent, speech
   3 - Inappropriate words, and garbled phrases consisting of words
   2 - Incomprehensible sounds
   1 - No sounds

III. Eye Opening
   4 - Spontaneous eye opening
   3 - Eyes open to speech
   2 - Eyes open to pain
   1 - No eye opening

Glasgow Coma Scale = I + II + III. A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 is a moderate injury, and 8 or less a severe brain injury.
EMERGENCY CALL-IN SCRIPT

“I am a NOAA Divemaster and I am calling to report a diving-related emergency requiring immediate medical assistance. The victim is a _____ (age) year old ______ (gender) who is ____________ (conscious/unconscious), with the following symptoms after diving with compressed gas…… (describe pain, dizziness, etc.)”

“We have placed the victim in the supine position, and have initiated basic first aid. We have also completed a field neurological exam, with the following results………… (note any deficits). The victim is on 100% oxygen by mask, and we have rendered the following additional treatment………… ( CPR, IV fluids, medications, etc.)

Last vital signs are as follows……”

Temp: _____ Pulse: _____ Resp: _____ B/P: _____/_____ 

“We are at the following location…….(location of diver / landmarks) and request immediate medical transport to………… (receiving facility of choice) via (air / ground ) transport”

Note: Do not terminate call….the receiving unit will end the call.
CONTACT INFORMATION

MEDICAL
Local EMS .................................................................(911)
USCG .................................................................VHF Channel 16
On-Call DMO.................................................................(855) 822-3483
(206) 526-6986
CAPT Joel Dulaigh, DMO (non-emergency) .......... (206) 526-6474 (work)
(206) 300-2098 (cell)
LT Gary Montgomery, DMO.................................(206) 256-6430
(830) 624-6283
MOC-P Medical Officer on call ...................... (206) 409-8725 (cell)
MOC-A Medical Officer on call ...................... (757) 615-6619 (cell)
Diver’s Alert Network (DAN) ...................... (919) 684-9111

ADMINISTRATIVE CONTACTS
Greg McFall, NOAA Diving Program Director ........... (206) 526-6705 (work)
(912) 596-2464 (cell)
Roger Mays, Acting NOAA Diving Safety Officer ...... (252) 728-8798 (work)
(252) 723-1612 (cell)

CHAMBER LOCATIONS & QUALIFIED PHYSICIANS (Seattle, WA)

Primary: Virginia-Mason Medical Center
1202 Terry Ave., Seattle, WA
Hyperbaric Department: (206) 583-6543
24-hour emergency line: (206) 583-6433

Secondary: Diver’s Institute of Technology
1341 Northlake Way, Seattle, WA
Chamber phone: (206) 783-5542

Tertiary: St. Joseph’s Medical Center – Tacoma
Hyperbaric Medical Service: (253) 426-6630
24-hour emergency line: (253) 426-6630

Additional Assistance: Divers Alert Network
24-hour emergency line: (919) 684-9111
CONTACT INFORMATION CON’T.

OTHER TRANSPORTATION CONTACTS

**U.S. Coast Guard** – Boat or Helicopter  
(206) 220-7001 or (800) 982-8813  
VHF Ch-16 or SFD dispatch

**SPD Harbor Patrol**  
(206) 684-4071  
VHF Ch-16 or SFD dispatch

**King County Marine Unit**  
911 or (206) 296-3311  
VHF Ch-16 or SFD dispatch

**Mercer Island Police / Fire**  
Rescue (206) 236-3600  
VHF Ch-16 or SFD dispatch

**Airlift Northwest**  
(206) 329-2569
NOAA DIVING PROGRAM
ACCIDENT MANAGEMENT & REPORTING PROCEDURES

Injury reported to supervisor

Injury requires > basic first aid?

No

No further action is required

Yes

Submit incident report within 8 hours for serious incidents and 24 hours for non-serious

NOAA employee?

No

Complete, but do not sign CD-137 and forward within 3 days to injured person’s immediate supervisor for signature and processing

Yes

▪ Complete form CD-137 and submit within 5 days to RSM
▪ Complete CA-1 and submit within 10 days to OWCP & RSM

Diving Injury?

No

Complete NOAA Diving Incident Report Form NF57-03-01

Yes
Complete the form then email to appropriate parties. Forward completed form within 24 hours of a job related injury, illness or near-miss. **Note:** Save to your Desktop.

### Immediate Notification Report

<table>
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<tr>
<th>Supervisor Completing Form</th>
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</thead>
<tbody>
<tr>
<td>Job Title</td>
<td></td>
</tr>
<tr>
<td>Last/First/Middle Name</td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

| Injured Employee or Affected Property Information |  |
| Work Location                               |  |
| Job Title                                   |  |
| Last/First/Middle Name                      |  |
| Telephone Number                           |  |
| Property Identification                     |  |

| Date/Time of Accident Occurrence |  |
| Location of Accident             |  |
| Accident Type (injury/death/equipment) |  |
| Description of Mishap            |  |

| Facility Corrective/Preventative Actions Implemented in Response to Accident |  |
| Preventative Action Recommendations |  |
| Additional Comments |  |
| Date/Time Form Completed/Submitted |  |
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

<table>
<thead>
<tr>
<th>Employee Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of employee (Last, First, Middle)</td>
</tr>
<tr>
<td>2. Social Security Number</td>
</tr>
<tr>
<td>3. Date of birth Mo. Day Yr.</td>
</tr>
<tr>
<td>4. Sex ☐ Male ☐ Female</td>
</tr>
<tr>
<td>5. Home telephone</td>
</tr>
<tr>
<td>6. Grade as of date of injury Level Step</td>
</tr>
<tr>
<td>7. Employee's home mailing address (Include city, state, and ZIP code)</td>
</tr>
<tr>
<td>8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of injury</th>
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</thead>
<tbody>
<tr>
<td>9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th &amp; Pine)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injury Occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Date injury occurred Mo. Day Yr.</td>
</tr>
<tr>
<td>11. Date of this notice Mo. Day Yr.</td>
</tr>
<tr>
<td>12. Employee's occupation</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Cause of injury (Describe what happened and why)</th>
</tr>
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<table>
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<tr>
<th>Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)</th>
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<table>
<thead>
<tr>
<th>Occupation code</th>
</tr>
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<tbody>
<tr>
<td>a.</td>
</tr>
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<table>
<thead>
<tr>
<th>Type code</th>
</tr>
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<tbody>
<tr>
<td>b.</td>
</tr>
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<table>
<thead>
<tr>
<th>Source code</th>
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<tbody>
<tr>
<td>c.</td>
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<table>
<thead>
<tr>
<th>OWCP Use - NOI Code</th>
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<table>
<thead>
<tr>
<th>Employee Signature</th>
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</thead>
<tbody>
<tr>
<td>15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:</td>
</tr>
<tr>
<td>☐ a. Sick and/or Annual Leave</td>
</tr>
<tr>
<td>☐ b. Continuation of regular pay (ERP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of § 5 USC 5594.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Signature of employee or person acting on his/her behalf</th>
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<tbody>
<tr>
<td>Date</td>
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<table>
<thead>
<tr>
<th>Witness Statement</th>
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<tbody>
<tr>
<td>16. Statement of witness (Describe what you saw, heard, or know about this injury)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of witness</th>
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<tbody>
<tr>
<td>Signature of witness</td>
</tr>
<tr>
<td>Date signed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>ZIP Code</td>
</tr>
</tbody>
</table>

Form CA-1
Rev. Apr. 1999

09/24/2015 (2)
Official Supervisor's Report: Please complete information requested below.

**Supervisor's Report**

17. Agency name and address of reporting office (Include city, state, and zip code)  
   OWCP Agency Code
   OSHA Site Code
   ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage  
   - CSRS
   - FERS
   - Other, (identify)

20. Regular work hours  
   - From:  
   - To:  

21. Regular work schedule  
   - Sun.
   - Mon.
   - Tues.
   - Wed.
   - Thurs.
   - Fri.
   - Sat.

22. Date of injury  
   - Mo.
   - Day
   - Yr.

23. Date notice received  
   - Mo.
   - Day
   - Yr.

24. Date work stopped  
   - Mo.
   - Day
   - Yr.

25. Date pay stopped  
   - Mo.
   - Day
   - Yr.

26. Date 45 day period began  
   - Mo.
   - Day
   - Yr.

27. Date returned to work  
   - Mo.
   - Day
   - Yr.

28. Was employee injured in performance of duty?  
   - Yes
   - No
   - (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?  
   - Yes (If "Yes," explain)
   - No

30. Was injury caused by third party?  
   - Yes
   - No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

32. Name and address of physician first providing medical care (Include city, state, ZIP code)

33. First date medical care received  
   - Mo.
   - Day
   - Yr.

34. Do medical reports show employee is disabled for work?  
   - Yes
   - No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses?  
   - Yes
   - No (If "No," explain)

36. If the employing agency contests the continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work  
   - $Per

**Signature of Supervisor and Filing Instructions**

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor  

Date

Supervisor's Title  

Office phone

39. Filing instructions  
   - No loss time and no medical expense. Place this form in employee's medical folder (SF-66-D)
   - No loss time, medical expense incurred or expected; forward this form to OWCP
   - Lost time covered by leave, LWOP, or GOR; forward this form to OWCP
   - First Aid Injury

Form CA-1.

Rev. Apr. 1999

09/24/2015 (2)
### Report of Accident/Illness

**SAFETY & HEALTH MANAGEMENT INFORMATION**

**TO BE COMPLETED BY EMPLOYEE**

1. Reason for Report:  □ Accident  □ Illness

2. Name: ____________________________  3. SSN: ____________________________
   (Last, First, M.I.)

4. Occupation: ____________________________  5. Phone: ____________________________

6. Date of Birth: ____________________________  7. Sex:  □ Male  □ Female

8. Date/Time of Accident/Illness: ____________________________  Time: ____________________________  □ AM  □ PM

9. Duty Station Address: ____________________________

10. Location of Incident: ____________________________

11. Description of Incident: ____________________________

12. Extent of Injury or Illness and Body Parts Affected: ____________________________

**Signature:** ____________________________  **Date:** ____________________________

**TO BE COMPLETED BY EMPLOYEE’S SUPERVISOR**

13. Medical Treatment?  □ Yes  □ No

14. Lost Time?  □ Yes  □ No

15. Investigator’s Name: ____________________________  15. Investigation Date: ____________________________

16. Findings: ____________________________

17. Amount of Property Damage: $ ____________________________

18. Corrective Action: ____________________________

19. Completion Date: ____________________________  □ Estimated  □ Actual

**Investigator’s Signature:** ____________________________  **Date:** ____________________________  **Phone:** ____________________________

**Distribution:** Original; Employee Supervisor; Employee; Safety Representative.

**ADMINISTRATION/PSG ELECTRONIC FORM**

09/24/2015 (2)
NOAA Diving Field Reference Guide

DIVING INCIDENT REPORT

NOTE: The Unit Diving Supervisor (UDS) shall use this form to report serious diving related injuries, including near-drowning, arterial gas embolism (AGE), decompression sickness (DCS), pulmonary barotrauma, or any diving injury that requires hospitalization. An additional narrative and detailed analysis of the incident must be attached. Contact the NOAA Diving Center (NDC) to determine whether an event or minor injury requires an incident report.

<table>
<thead>
<tr>
<th>DIVER NAME</th>
<th>TIME of INCIDENT</th>
<th>DATE of INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIVER CERTIFICATION</th>
<th>DIVE UNIT</th>
<th>LOCATION of INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>DIVER CURRENT MEDICATIONS</th>
<th>DIVER CURRENT HEALTH PROBLEMS</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX (M/F)</th>
<th>HIGHEST DIVE CERTIFICATION LEVEL</th>
<th>CERTIFYING DIVING ASSOCIATION</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>TOTAL # of YEARS DIVING</th>
<th>TOTAL # of DIVES</th>
<th>TOTAL # of DIVES in the PAST 6 MONTHS</th>
<th>PREVIOUS DIVE INCIDENTS and DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>BREATHING LOOP</th>
<th>DIVER DRESS</th>
<th>DIVE CYLINDER TYPE and SIZE</th>
<th>CYLINDER PRESSURE IN</th>
<th>SEP ISSUED EQUIPMENT?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Circuit</td>
<td>None / Dive Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi Closed /</td>
<td>Wet Suit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed Circuit</td>
<td>Thickness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surface Supplied</td>
<td>Dry Suit</td>
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</table>

<table>
<thead>
<tr>
<th>BREATHING GAS</th>
<th>CYLINDER PRESSURE OUT</th>
<th>DIVER FAMILIAR WITH EQUIPMENT?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME of ON-SITE DIVING SUPERVISOR / LEAD DIVER</th>
<th>AIR TEMP (°F)</th>
<th>WATER TEMP (°F)</th>
<th>U/W VISIBILITY (FT)</th>
<th>CURRENT SPEED (KTS)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME of DIVE BUDDY</th>
<th>DIVE PURPOSE</th>
<th>DIVE LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>DIVE BUDDY AFFILIATION</th>
<th>DIVE PLATFORM</th>
<th>SURFACE CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th># of DIVES on DAY of INCIDENT</th>
<th># of DIVES on PREVIOUS DAY</th>
<th>TYPE OF DIVE</th>
<th>DIVES CONDUCTED WITH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DIVE #</th>
<th>Start Time</th>
<th>Max Depth (Feet)</th>
<th>Bottom Time (Minutes)</th>
<th>End Time</th>
<th>Surface Interval (HH:MM)</th>
<th>Deco Stop? (Y/N)</th>
<th>Safety Stop? (Y/N)</th>
<th>Stop Profile (Depth / Time)</th>
<th>Cold or Arduous? (Y/N)</th>
<th>Fast Ascent? (Y/N)</th>
<th>Incident Dive? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Was this dive typical of the diver's normal type of diving?  YES  NO

If NO, explain:

Describe any problems encountered during the incident dive or previous dives:

1.
2.
3.
4.
5.
6.
**NOAA Diving Field Reference Guide**

**DIVING INCIDENT REPORT FORM**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**SECTION VI. SYMPTOMS, PRE-DIVE HEALTH, and ON-SITE MEDICAL TREATMENT**

**DATE OF SYMPTOM ONSET**

**DESCRIPTION OF SYMPTOMS and LOCATION on BODY**

**TIME OF SYMPTOM ONSET**

**DESCRIPTION of PRE-DIVE HEALTH**

**DESCRIPTION of PRE-DIVE ALCOHOL CONSUMPTION (previous 24 hours)**

**DESCRIPTION of PRE-DIVE REST or FATIGUE LEVELS**

**DESCRIPTION of STRENuous EXERCISE (6 hours prior and 12 hours post-dive)**

**SUSPECTED INJURIES or ILLNESSES**

- ☐ AGE
- ☐ DCS
- ☐ Pulmonary Barotrauma
- ☐ Other Barotrauma
- ☐ None
- ☐ Other

**ON-SITE OXYGEN ADMINISTRATION**

- Delivery Method

**ON-SITE FIRST-AID TREATMENT PROVIDED**

<table>
<thead>
<tr>
<th>☐</th>
<th>Time Started</th>
<th>INITIAL EMERGENCY CONTACT (name of person or agency)</th>
</tr>
</thead>
</table>

**TIME OF INITIAL EMERGENCY CONTACT**

**TIME TRANSPORTATION STARTED**

**FIRST-AID TREATMENT PROVIDED DURING TRANSPORT**

**EMERGENCY TRANSPORT METHOD(S)**

**SECTION VII. MEDICAL INFORMATION – Hospital (Attach all Emergency Room, Hyperbaric Unit, and follow-up medical records.)**

<table>
<thead>
<tr>
<th>HOSPITAL NAME and ADDRESS</th>
<th>HOSPITAL TREATMENT</th>
<th>DATE of ARRIVAL</th>
<th>TIME of ARRIVAL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HYPERBARIC UNIT NAME and ADDRESS</th>
<th>CHAMBER TYPE</th>
<th>CHAMBER TREATMENT</th>
<th>TREATMENT TABLE / DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Monoplace</td>
<td>Treatment #1 Time Started _____ Time Stopped _____</td>
<td>TABLE EXTENSIONS</td>
</tr>
<tr>
<td></td>
<td>☐ Multiplace</td>
<td>Treatment #2 Time Started _____ Time Stopped _____</td>
<td>RETREATMENT TABLE / DESCRIPTION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment #3 Time Started _____ Time Stopped _____</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESCRIBE WHEN RELIEF FROM SYMPTOMS OCCURRED</th>
<th>DESCRIBE ANY RESIDUAL SYMPTOMS AFTER TREATMENT</th>
<th>DAYS of RESIDUAL SYMPTOMS</th>
<th>FINAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ DCS I ☐ DCS II ☐ A6E ☐ Pulmonary Barotrauma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UDS NAME</th>
<th>UDS SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

**NOTE:** A Diving Incident Report shall be completed by the UDS and submitted to their Line Office Diving Officer (LODO) within 10 days of the diving incident.

A full report includes the following items:

1. Diving Incident Report Form (NOAA Form 57-03-01)
2. Cover memorandum providing a narrative of the diving incident, including causal analysis and recommendations for prevention of future injuries.
3. Medical records associated with any medical treatment of injuries resulting from this incident.

The LODO shall submit the UDS report, along with their own causal analysis and recommendations for prevention of future injuries to the Director, NOAA Diving Program within 30 days of the diving incident.