

B.8. Crew Record Form

CREW RECORD FORM			
Title			
Given Name			
Maiden Name			
Family Name			
Date of Birth			
Gender M/F			
Age			
Address /Tel			
Profession			
GP Name /Address			
Next of Kin/Relative	Name		
	Address		
	Telephone		
	Relationship		
Travelling with (names)			
Current location (hotel, hospital, Mortuary)			
Nature of Injuries (Tick Appropriate Box <input checked="" type="checkbox"/>)			
<input type="checkbox"/> Uninjured	<input type="checkbox"/> Injured	<input type="checkbox"/> Dead	<input type="checkbox"/> Minor
<input type="checkbox"/> Serious	<input type="checkbox"/> Critical	<input type="checkbox"/> Fatal	<input type="checkbox"/> Body normal
<input type="checkbox"/> Body disfigured	<input type="checkbox"/> Body Burnt	<input type="checkbox"/> Body Mutilated	
Do you agree that these details may be passed to local police or other authorities?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Next of kin/relative informed by:		Date	Time