



# Demining Accident Report



## General Information

Task #	AF _____ / _____ / _____ / _____	IMSMA ID:	
AMAC		Report received :	
Reported by :		Date of report :	
Position:		Team Name :	
Organization:		Data Entry date :	
Field Officer :			

## General demining accident information:

Demining accident ID :		Data entry by :	
Date and time of dem. acc. :		Date of report :	
Reported by :			
Data entry :			

Kind of area where demin.acc. occurred : \_\_\_\_\_

Clearance in progress?  Yes  No

Number of persons involved : \_\_\_\_\_

Was area marked?  Yes  No

Number of casualties : \_\_\_\_\_

Was mine/UXO Marked?  Yes  No

## Casualty data

Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Father Name:		Date of Birth :
Nationality:		
Position :		

## Location of accident

Region/	District:
Province	Village:
Distance from nearest village/city:_____ km	

<b>Coordinates should be in Lat / Long WGS84 DD MM SS.S</b> LL WGS84(DD,MM,SS)	
Long :	Coord. fixed by: <input type="checkbox"/> GPS
Lat:	



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## Injuries

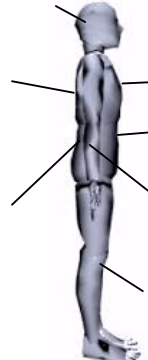
Was the person injured or killed?  Killed  Injured If killed, location of death:

- In site:  At health care facility:
- During transport to health care facility :
- Other: ---

**Loss of:**

Eyesight <input type="checkbox"/>		Eyesight <input type="checkbox"/>
Hearing <input type="checkbox"/>		Hearing <input type="checkbox"/>
<b>Right side</b>		<b>Left side</b>
Arm <input type="checkbox"/>		Arm <input type="checkbox"/>
Hand/Finger <input type="checkbox"/>		Hand/Finger <input type="checkbox"/>
<input type="checkbox"/> Above Knee		<input type="checkbox"/> Above Knee
Leg <input type="checkbox"/>		Leg <input type="checkbox"/>
<input type="checkbox"/> Below Knee		<input type="checkbox"/> Below Knee
Foot/Toes <input type="checkbox"/>		Foot/Toes <input type="checkbox"/>

**Other Injuries**

Head/Neck <input type="checkbox"/>		Chest <input type="checkbox"/>
Back <input type="checkbox"/>		Abdomen <input type="checkbox"/>
Pelvis/Buttocks <input type="checkbox"/>		Upper limbs <input type="checkbox"/>
		Lower limbs <input type="checkbox"/>

## Other Information:

First medical facility reached: -----

Time until first facility reached :----- h

Name of first hospital reached :-----

Time until first hospital reached :----- h

Did the person wear protective equipment ?  Yes  No

Was the equipment effective?  Yes  No

Medical report reference (if available) :

## List of other Casualties



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## Device that caused the demining accident :

Device category (Landmines×, bombs...)	Device type (AP, AT, UXO etc.)	Model	Qty	Anti-lift fitted	Booby trapped

## Equipment Damaged:

## Other Comments:

## Data Collector information:

Tasked by:		Verification by:	AMAC:
Reported by (T. Leader) Name		Location:	
Location :		Date :	
T. Leader Signature:		Name :	
Checked by Supervisor (Name)		Position :	
Supervisor Signature		Signature:	
Date:		Data entry by:	
Checked by Site Officer (Name)		Data entry date:	
Site Officer Signature:		Signature:	