

FLASH MISHAP REPORT, MARINE CORPS BASE, CAMP LEJEUNE

OPNAV P5102.1D/MCO P5102.1B *“Navy and Marine Corps Mishap and Safety Investigation Reporting and Record Keeping Manual”* – Para. 1001: “Investigation procedures, reports, and records are designed to assist all leaders in identifying causal factors and formulating corrective measures to prevent mishap recurrence.” The validity of many aspects of an investigation is highest when the investigative actions start immediately after the accident occurs. The flash mishap report (FMR) will be used to facilitate the rapid onset of mishap investigation.

All Shop/Unit Supervisors (Appropriated Civilian, NAFI): Within 2 hours of learning that an employee under your supervision has suffered an injury requiring medical treatment (including class A,B, & C mishaps as described in MCO P5102.1B), complete this form in its entirety and follow the instructions for your respective area: (NOTE: ALL MISHAPS/NEAR MISSES MUST BE RECORDED AND KEPT AT THE UNIT LEVEL FOR LATER REVIEW)

- **Appropriated Civilian Shop Supervisors:** Forward the completed form to: (1) Injury Compensation Program Administrator at fax 910-451-9063; (2) Review & Analysis Safety Officer at fax 910-451-3152 or email to McCartyMD@usmc-mccs.org; (3) Designated personnel in your chain of command as directed.
- **Non-appropriated (NAFI) Civilian Shop Supervisors:** Forward the completed form to: (1) HR Office at FAX 910-451-6776 or Email to GarciaVL@usmc-mccs.org; (2) Review & Analysis Safety Officer at fax 910-451-3152 or email to McCartyMD@usmc-mccs.org; (3) designated personnel in your chain of command as directed.

1. Name, Rank, Job Title of injured: _____
2. Employee’s shop/name and Bldg number: _____
3. Employee’s work phone number: _____
4. Date of Mishap: _____ Time of Mishap: _____
5. Mishap location: _____
6. Duty Status (Circle one): On Duty or Off Duty
7. Brief description of mishap. (Answer Who, What, When, Why, Where. Describe injury) _____

8. Witness’s name(s) _____ Witness’s phone number(s): _____

9. Shop/Unit Supervisor’s name/Phone#: _____
10. Medical Treatment Sought: _____ If Yes, where? _____
 _____ If No, **Employee must sign and explain:** _____
