

## NATIONAL TRANSPORTATION SAFETY BOARD • PILOT/OPERATOR AIRCRAFT ACCIDENT/INCIDENT

REPORT Use this form (Form 6120.1) to report civil and public aircraft accidents and incidents

## BASIC INFORMATION

## Accident/Incident Location

Nearest City/Place: Palmer State: AKZIP: 99645 Country: USALatitude: 61.4420784 Longitude: -148.7221934

(Enter in decimal degrees or degrees:minutes:seconds)

## Accident/Incident Date/Time

Date: 09/15/2024 Local Time: 14:50

mm/dd/yyyy

Time Zone: AKSTCollision with Other Aircraft: ☐ Midair ☐ On-ground ☒ None

## AIRCRAFT INFORMATION

Registration Number: N4118ZManufacturer: PIPERModel: Super CubSerial Number: 18-8159Year of Manufacture: 1964Amateur-Built: ☐ Yes ☒ No If Yes: ☐ Original Design ☐ Kit/Plans Make: \_\_\_\_\_☐ IFR-Equipped and Certified  
☐ Commercial Space Flight  
☐ Unmanned AircraftMaximum Gross Weight: 1750 lbs.Weight at Time of Accident/Incident: 1410 lbs.Number of Seats: 2 Flight Crew Seats: 1Cabin Crew Seats: 2 Passenger Seats: 1Number of Engines: 1Category of Aircraft  
(Select one)

- ☒ Airplane  
☐ Balloon  
☐ Blimp/Dirigible  
☐ Glider  
☐ Gyroplane  
☐ Helicopter  
☐ Powered Lift  
☐ Rocket  
☐ Ultralight  
☐ Unknown

Type of Airworthiness Certificate  
(Check all that apply)

- Standard**  
☒ Normal  
☐ Aerobatic  
☐ Balloon  
☐ Commuter  
☐ Transport  
☐ Utility  
☐ Certificate of Authorization or Waiver (COA)  
☐ None
- Special**  
☐ Restricted  
☐ Limited  
☐ Provisional  
☐ Special Flight  
☐ Experimental  
☐ Special Light-Sport  
☐ Experimental Light-Sport  
☐ Unknown

Landing Gear  
(Check all that apply)

- ☐ Retractable  
☐ Tricycle  
☒ Tailwheel  
☐ Emergency Float  
☐ Float  
☐ Amphibian  
☐ Other Launch/Recovery System  
☐ None
- ☐ High Skid  
☐ Skid  
☐ Ski/Wheel  
☐ Hull  
☐ Ski  
☐ Unknown

## Engine Type (Select one)

- ☒ Reciprocating  
☐ Turbo Shaft  
☐ Turbo Prop  
☐ Turbo Jet  
☐ Turbo Fan  
☐ Electric  
☐ Liquid Rocket  
☐ Solid Rocket  
☐ Hybrid Rocket  
☐ None  
☐ Unknown

## Fuel System Type (Reciprocating)

- ☐ Carburetor ☒ Fuel Injected

| Engine | Engine Manufacturer | Engine Model/Series | Engine Serial Number | Date of Mfg.<br>(mm/dd/yyyy) | Rated Power<br><input checked="" type="radio"/> Horsepower or<br><input type="radio"/> Lbs. of Thrust | Total Time<br>(hours) | Time Since:<br>Inspection (hours) Overhaul (hours) |
|--------|---------------------|---------------------|----------------------|------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------|
| Eng. 1 | Lycoming            | O-320-C1G           | L-38045-36A          | 07/14/01                     | 180                                                                                                   | 841.6                 | 3 841.6                                            |
| Eng. 2 |                     |                     |                      |                              |                                                                                                       |                       |                                                    |
| Eng. 3 |                     |                     |                      |                              |                                                                                                       |                       |                                                    |
| Eng. 4 |                     |                     |                      |                              |                                                                                                       |                       |                                                    |

## Last Inspection Type

- ☒ 100-Hour  
☐ AAIP  
☐ Annual  
☐ Continuous Airworthiness  
☐ Condition Inspection  
☐ Unknown

Date of Last Inspection: 06/20/2024

mm/dd/yyyy

Airframe Total Time: 3291.6 hrs

Hours measured at (Select one)

☒ Last Inspection ☐ Time of Accident/Incident

## Type of Maintenance Program (Select One)

- ☒ Annual  
☐ Conditional (Amateur-built only)  
☐ Manufacturer's Inspection Program  
☐ Other Approved Inspection Program  
☐ (AAIP) Continuous Airworthiness  
☐ Other, specify: \_\_\_\_\_

## Description of Fire Extinguishing System

- ☐ None  
☒ Specify: \_\_\_\_\_

## Additional Equipment

- ☐ ADS-B  
☐ Airframe Parachute  
☐ Angle of Attack Indicator  
☐ Autopilot  
☐ Autopilot/FMS, Model: \_\_\_\_\_  
☐ Coupled Flight Director  
☐ Data Recorder  
☒ Device Stall Warning System  
☐ Electronic Flight Bag or Handheld Device  
☒ Electronic Multifunction Display  
☒ Electronic Primary Flight Display  
☐ Flight Management System

- ☒ Handheld GPS  
☐ Heads Up Display  
☐ Night Vision Goggles  
☐ Onboard Weather  
☐ Primary Flight Display  
☐ SAS, Axis (circle one): 2, 3, 4, Model: \_\_\_\_\_  
☐ Satellite Tracking Device  
☐ Stall Warning System  
☐ Video Recording Device  
☐ Wire Strike Detection  
☐ Wire Strike Protection  
☐ Other, Specify: \_\_\_\_\_

ELT Installed: ☒ Yes ☐ No If Yes:ELT Manufacturer: ArtesModel or Part No.: 345TSO No.: ☐ C91 (121.5 MHz) ☒ C91a (121.5 MHz)☐ C126 (406 MHz)Was ELT still mounted in aircraft? ☒ Yes ☐ NoWas ELT still connected to antenna? ☒ Yes ☐ NoDid ELT activate? ☒ Yes ☐ NoIf activated: Did ELT aid in locating aircraft? ☒ Yes ☐ NoIf not activated: Indicate Reason: ☐ Impact Damage☐ Fire Damage ☐ Battery ☐ Expired/Damaged ☐ Unknown

## Propeller 1

- ☒ Fixed Pitch  
☐ Controllable Pitch  
☐ Ground Adjustable

Manufacturer: McCauleyModel: 1A200/FA8420

## Propeller 2

- ☐ Fixed Pitch  
☐ Controllable Pitch  
☐ Ground Adjustable

Manufacturer: \_\_\_\_\_

Model: \_\_\_\_\_

**OWNER/OPERATOR INFORMATION****Registered Aircraft Owner**Name: Super Cub1 LLC

Fractional Ownership Aircraft:

☐ Yes ☐ NoCity: AnchorageState: AKZIP: 99501Country: Anc**Operator of Aircraft**☒ The Operator is also the Registered Owner☐ Same address as Registered Owner

Name: \_\_\_\_\_

Doing Business As: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Air Carrier/Operator Designator (4-character code): \_\_\_\_\_

ZIP: \_\_\_\_\_

Country: \_\_\_\_\_

**Operating Certificates Held**

(Check all that apply)

- ☒ None  
☐ Flag Carrier Operating Certificate (FAR 121)  
☐ Supplemental  
☐ Air Cargo  
☐ Foreign Air Carriers (FAR 129)  
☐ Rotorcraft External Load (FAR 133)  
☐ Commuter Air Carrier (FAR 135)  
☐ On-Demand Air Taxi (FAR 135)  
☐ Commercial Air Tour (FAR 136)  
☐ Agricultural Aircraft (FAR 137)  
☐ Pilot School (FAR 141)  
☐ Certificate of Authorization or Waiver (COA)  
☐ Commercial Space Transportation  
     Experimental Permit  
☐ Commercial Space Transportation License  
☐ Other Operator of Large Aircraft

**Regulation Flight Conducted Under**

- ☒ FAR 91    ☐ FAR 129    ☐ FAR 415  
☐ FAR 103    ☐ FAR 133    ☐ FAR 431  
☐ FAR 121    ☐ FAR 135    ☐ FAR 435  
☐ FAR 125    ☐ FAR 137    ☐ FAR 437  
☐ FAR 450  
☐ FAR 91 Special Flight  
☐ Non-US, Commercial  
☐ Non-US, Non-commercial  
☐ Public Aircraft (Select one)  
     ☐ Armed Forces  
     ☐ Federal  
     ☐ State  
     ☐ Local  
☐ Unknown

**Revenue Operation for FAR 121, 125, 129, 135**

(Select one for each group)

- ☐ Scheduled or Commuter    ☐ Domestic  
☐ Non-Scheduled or Air Taxi    ☐ International  
☐ Passenger  
☐ Cargo  
☐ Mail Contract Only

**Purpose of Flight for FAR 91, 103, 133, 137 (Select one)**

- ☐ Aerial Application    ☐ Firefighting  
☐ Aerial Observation    ☐ Flight Test  
☐ Air Drop    ☐ Glider Tow  
☐ Air Race/Show    ☐ Instructional  
☐ Banner Tow    ☐ Other Work Use  
☐ Business    ☒ Personal  
☐ Executive/Corporate    ☐ Positioning  
☐ External Load    ☐ Skydiving  
☐ Ferry    ☐ Unknown

**Revenue Sightseeing Flight**☐ Yes ☒ No**Air Medical Flight**☐ Yes ☒ No**AIRPORT INFORMATION (Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)**

Airport Name: \_\_\_\_\_

Distance From Airport Center: \_\_\_\_\_ sm.

Airport Identifier: \_\_\_\_\_

Direction From Airport: \_\_\_\_\_ degrees true

Proximity to Airport: ☐ Off Airport/Airstrip ☐ On Airport/Airstrip ☐ N/A

Airport Elevation: \_\_\_\_\_ ft. MSL

**Runway Information**

Runway ID: \_\_\_\_\_ Length: \_\_\_\_\_ ft. Width: \_\_\_\_\_ ft.

**Runway/Landing Surface (Check all that apply)**

- ☐ Asphalt    ☐ Grass/Turf    ☐ Ice    ☐ Snow  
☐ Concrete    ☐ Gravel    ☐ Macadam    ☐ Water  
☐ Dirt    ☐ Helideck    ☐ Metal/Wood    ☐ Unknown  
☐ Elevated Heliport    ☐ Helistop    ☐ Off-site landing area

**Condition of Runway/Landing Surface (Check all that apply)**

- ☐ Dry    ☐ Snow-Compacted    ☐ Water-Calm  
☐ Holes    ☐ Snow-Crusted    ☐ Water-Choppy  
☐ Ice Covered    ☐ Snow-Dry    ☐ Water-Glassy  
☐ Rough    ☐ Snow-Wet    ☐ Wet  
☐ Rubber Deposits    ☐ Soft  
☐ Slush-Covered    ☐ Vegetation    ☐ Unknown

**Approach/Departure Segment (Select one)**

- ☐ Taxi    ☐ VFR Departure    ☐ On Instrument Approach    ☐ Downwind    ☐ Low Approach  
☐ Takeoff    ☐ IFR Departure Procedure/Clearance    ☐ Landing    ☐ Base    ☐ Go Around  
☐ Initial Climb    ☐ Final    ☐ Aborted Landing (after touchdown)  
☐ Crosswind    ☐ Unknown

**IFR Approach (Check all that apply)**

- ☐ None  
☐ ADF/NDB    ☐ PAR    ☐ MLS    ☐ Practice  
☐ SDF    ☐ Sidestep    ☐ LDA    ☐ GPS  
☐ VOR/TWOR    ☐ ILS    ☐ ASR    ☐ Unknown  
☐ VOR/DME    ☐ Localizer Only    ☐ Visual  
☐ TACAN    ☐ LOC-back course    ☐ Contact  
☐ RNAV    ☐ Circling

**VFR Approach (Check all that apply)**

- ☐ None  
☐ Traffic Pattern    ☐ Stop and Go  
☐ Straight-In    ☐ Touch and Go  
☐ Valley/Terrain Following    ☐ Simulated Forced Landing  
☐ Go Around    ☐ Forced Landing  
☐ Full Stop    ☐ Precautionary Landing  
☐ Unknown

**"FLIGHT CREWMEMBER 1" INFORMATION****"Flight Crewmember 1" Responsibilities at the Time of Accident/Incident**

☒ Captain ☐ First Officer ☐ Pilot ☐ Co-Pilot ☐ Student Pilot ☐ Flight Instructor ☐ Check Pilot ☐ Flight Engineer ☐ Other Flight Crew

"Flight Crewmember 1" was pilot flying ☐ Yes ☐ No

**"Flight Crewmember 1" Identification**

First Name: Marius

City of Residence: Anchorage

Middle Initial: NMN

State: AK

ZIP: 99501

Last Name: Maxwell

Country: USA

Age at time of Accident/Incident: 63

Date of Birth: [REDACTED] (mm/dd/yyyy)

Certificate Number: [REDACTED]

**Degree of Injury**

☒ None ☐ Serious  
☐ Unknown ☐ Fatal  
☐ Minor

**Seat Occupied**

☐ Left ☐ Front ☐ Unknown  
☐ Right ☐ Rear  
☐ Center ☐ Single

**Restraint Type****Available**

☐ None  
☐ Lap only  
☐ 3-point  
☐ 4-point  
☐ 5-point  
☐ Unknown

**Used**

☐ None  
☐ Lap only  
☐ 3-point  
☐ 4-point  
☐ 5-point  
☐ Unknown

☐ Supplemental. Restraint type: \_\_\_\_\_

**Inflatable Restraints**

☒ Not Installed  
☐ Installed  
☐ Not Deployed  
☐ Deployed  
☐ Unknown

**Pilot Certificate(s) (Check all that apply)**

☐ None ☐ Flight Instructor ☒ Commercial  
☐ US Military ☐ Private ☐ Recreational  
☐ Airline Transport ☐ Foreign ☐ Sport  
☐ Student ☐ Flight Engineer

**Principal Occupation**

☐ Pilot  
☒ Other  
☐ Unknown

**Medical Certificate**

☐ None ☒ Class 3  
☐ Class 1 ☐ Driver's License (Sport Pilot only)  
☐ Class 2 ☐ Unknown

**Medical Certificate Validity**

☐ Without limitations/waivers ☐ Unknown  
☐ With limitations/waivers ☐ N/A  
☐ Special Issuance

**Date of Last Medical**

02/27/2023  
mm/dd/yyyy

**Medical Certificate Limitations**

Must use corrective lens(es) to meet vision standards at all required distances.

**Medical Certificate Special Limitations****Personal Flight Equipment (Check all that apply)**

☐ Fire resistant flight suit ☐ Helmet ☐ Laser protective visor/glasses ☐ Personal locator beacon(s) (PLB) ☐ Fire resistant gloves  
☐ Helmet visor ☐ Night vision goggles ☐ Personal flotation ☐ Other: \_\_\_\_\_

**Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:**

06/10/2023  
mm/dd/yyyy

**Flight Review Aircraft**

Make: PIPER

Model: Super Cub

**Airplane Rating(s) (Check all that apply)**

☐ Single-Engine Land  
☐ Single-Engine Sea  
☒ Multiengine Land  
☐ Multiengine Sea

**Other Aircraft Rating(s) (Check all that apply)**

☐ None  
☐ Airship  
☐ Balloon  
☐ Glider  
☐ Gyroplane  
☒ Helicopter  
☐ Powered Lift

**Instrument Rating(s) (Check all that apply)**

☐ None  
☒ Airplane  
☐ Helicopter  
☐ Powered Lift

**Instructor Rating(s) (Check all that apply)**

☒ None ☐ Instrument Airplane  
☐ Airplane Single-Engine ☐ Instrument Helicopter  
☐ Airplane Multiengine ☐ Helicopter  
☐ Gyroplane ☐ Glider  
☐ Powered lift ☐ Sport

**Type Ratings and Applicable Logbook Endorsements**

NA-51, MiG-15/17 (VFR), LR-35 SIC

**Student Endorsements (Include dates)**

| Flight Time (Enter hours for each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |           | Rotorcraft | Glider | Lighter Than Air | Multi-engine Rotorcraft | Tail-wheel |
|----------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|-----------|------------|--------|------------------|-------------------------|------------|
|                                        |              |                   |                        |                      |       | Actual     | Simulated |            |        |                  |                         |            |
| Total Time                             | 5220         | 210               | 1140                   | 2410                 | 127   | 345        | 185       | 1120       | 0      | 0                | 0                       | 550        |
| Pilot in Command (PIC)                 | 4215         | 205               | 2150                   | 1920                 | 121   | 295        | 0         | 975        | 0      | 0                | 0                       | 515        |
| Time as Instructor                     | 0            | 0                 | 0                      | 0                    | 0     | 0          | 0         | 0          | 0      | 0                | 0                       | 0          |
| This Make/Model                        |              |                   |                        |                      | 0     | 0          | 0         |            |        |                  |                         |            |
| Last 90 Days                           | 25           | 11                | 25                     | 0                    | 0     | 0          | 0         | 0          | 0      | 0                | 0                       | 25         |
| Last 30 Days                           | 6            | 3                 | 6                      | 0                    | 0     | 0          | 0         | 0          | 0      | 0                | 0                       | 6          |
| Last 24 Hours                          | 3            | 3                 | 3                      | 0                    | 0     | 0          | 0         | 0          | 0      | 0                | 0                       | 3          |

**"FLIGHT CREWMEMBER 2" INFORMATION****"Flight Crewmember 2" Responsibilities at the Time of Accident/Incident**

☐ Captain ☐ First Officer ☐ Pilot ☐ Co-Pilot ☐ Student Pilot ☐ Flight Instructor ☐ Check Pilot ☐ Flight Engineer ☐ Other Flight Crew

"Flight Crewmember 2" was pilot flying ☐ Yes ☐ No

**"Flight Crewmember 2" Identification**

First Name: \_\_\_\_\_

City of Residence: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Last Name: \_\_\_\_\_

Country: \_\_\_\_\_

Age at time of Accident/Incident: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

Certificate Number: \_\_\_\_\_

| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Serious<br><input type="radio"/> Unknown <input type="radio"/> Fatal<br><input type="radio"/> Minor                                                                                                                                                                                                                                                                                              |                                | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single              |  | <b>Restraint Type</b><br><table border="0"> <tr> <th>Available</th> <th>Used</th> </tr> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> None</td> </tr> <tr> <td><input type="radio"/> Lap only</td> <td><input type="radio"/> Lap only</td> </tr> <tr> <td><input type="radio"/> 3-point</td> <td><input type="radio"/> 3-point</td> </tr> <tr> <td><input type="radio"/> 4-point</td> <td><input type="radio"/> 4-point</td> </tr> <tr> <td><input type="radio"/> 5-point</td> <td><input type="radio"/> 5-point</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td><input type="radio"/> Unknown</td> </tr> </table> |  | Available                                         | Used | <input type="radio"/> None | <input type="radio"/> None | <input type="radio"/> Lap only | <input type="radio"/> Lap only | <input type="radio"/> 3-point | <input type="radio"/> 3-point | <input type="radio"/> 4-point | <input type="radio"/> 4-point | <input type="radio"/> 5-point | <input type="radio"/> 5-point | <input type="radio"/> Unknown | <input type="radio"/> Unknown | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|------|----------------------------|----------------------------|--------------------------------|--------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Available                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Used                           |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="radio"/> None     |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> Lap only                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Lap only |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> 3-point                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> 3-point  |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> 4-point                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> 4-point  |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> 5-point                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> 5-point  |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Unknown  |                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial<br><input type="checkbox"/> US Military <input type="checkbox"/> Private <input type="checkbox"/> Recreational<br><input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign <input type="checkbox"/> Sport<br><input type="checkbox"/> Student <input type="checkbox"/> Flight Engineer |                                |                                                                                                                                                                                                                                                  |  | <b>Supplemental Restraint type:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                   |                                | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown |  | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                                                       |  | <b>Date of Last Medical</b><br>_____ (mm/dd/yyyy) |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |
| <b>Medical Certificate Limitations</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                              |                                |                                                                                                                                                                                                                                                  |  | <b>Medical Certificate Special Limitations</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |      |                            |                            |                                |                                |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                |  |

**Personal Flight Equipment (Check all that apply)**

☐ Fire resistant flight suit ☐ Helmet ☐ Laser protective visor/goggles ☐ Personal Locator Beacon(s) (PLB) ☐ Fire resistant gloves  
☐ Helmet visor ☐ Night vision goggles ☐ Personal flotation ☐ Other: \_\_\_\_\_

**Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:** \_\_\_\_\_ (mm/dd/yyyy)

**Flight Review Aircraft**

Make: PIPER

Model: S' PIPER CUB

|                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Airplane Rating(s) (Check all that apply)</b><br><input type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea |  | <b>Other Aircraft Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |  | <b>Instrument Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |  | <b>Instructor Rating(s) (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multiengine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered lift<br><input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

**Type Ratings and Applicable Logbook Endorsements****Student Endorsements (Include dates)**

| Flight Time (Enter hours for each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |           | Rotorcraft | Glider | Lighter Than Air | Multi-engine Rotorcraft | Tail-whisker |
|----------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|-----------|------------|--------|------------------|-------------------------|--------------|
|                                        |              |                   |                        |                      |       | Actual     | Simulated |            |        |                  |                         |              |
| Total Time                             |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| Pilot in Command (PIC)                 |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| Time as Instructor                     |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| This Make/Model                        |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| Last 90 Days                           |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| Last 30 Days                           |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |
| Last 24 Hours                          |              |                   |                        |                      |       |            |           |            |        |                  |                         |              |

| ADDITIONAL FLIGHT CREWMEMBERS (Exclusive of cabin crew, complete the following information.)                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Crewmember Information</b><br><br>First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                 |                                                                                                                                              | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single<br><input type="radio"/> Right <input type="radio"/> Unknown<br><input type="radio"/> Front                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                          |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit <input type="checkbox"/> Helmet <input type="checkbox"/> Laser protective visor/glasses <input type="checkbox"/> Personal locator beacon(s) (PLB) <input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Helmet visor <input type="checkbox"/> Night vision goggles <input type="checkbox"/> Personal flotation <input type="checkbox"/> Other: _____ |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer                |                                                                                                                                                                                                                 |                                                                                                                                              | <b>Restraint Type</b><br><table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown<br/> <input type="radio"/> Supplemental.<br/>           Restraint type: _____         </td> <td style="width: 50%; vertical-align: top;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown         </td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                             |
| <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____                                                                                                                                                                                                     | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs.                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Additional Crewmember Information</b><br><br>First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                 |                                                                                                                                              | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single<br><input type="radio"/> Right <input type="radio"/> Unknown<br><input type="radio"/> Front                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                          |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit <input type="checkbox"/> Helmet <input type="checkbox"/> Laser protective visor/glasses <input type="checkbox"/> Personal Locator Beacon(s) (PLB) <input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Helmet visor <input type="checkbox"/> Night vision goggles <input type="checkbox"/> Personal flotation <input type="checkbox"/> Other: _____ |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer                |                                                                                                                                                                                                                 |                                                                                                                                              | <b>Restraint Type</b><br><table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown<br/> <input type="radio"/> Supplemental.<br/>           Restraint type: _____         </td> <td style="width: 50%; vertical-align: top;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown         </td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                             |
| <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____                                                                                                                                                                                                     | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs.                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| PASSENGER(S) / OTHER PERSONNEL (Include cabin crew; continue on separate sheet, if necessary.)                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| Number of Passengers: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| Passenger Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 | Seat                                                                                                                                         | Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Restraint Type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Inflatable Restraints                                                                                                                                                                                                                                                                | Age                                                                                                                                                                                                             |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last name: _____ Country: _____<br><br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                 | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br><br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown<br/> <input type="radio"/> Supplemental.<br/>           Restraint type: _____         </td> <td style="width: 50%; vertical-align: top;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown         </td> </tr> </table> | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Under 5 years<br><br>If under 5 years:<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |
| <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental.<br>Restraint type: _____                                                                                                                                                                                                     | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit <input type="checkbox"/> Helmet <input type="checkbox"/> Laser protective visor/glasses <input type="checkbox"/> PLB <input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Night vision goggles <input type="checkbox"/> Helmet visor <input type="checkbox"/> Personal flotation <input type="checkbox"/> Other: _____                              |                                                                                                                                                                                                                 |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                             |

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                                                      | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><input type="checkbox"/> 5 under 1 years<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Child<br><input type="checkbox"/> Unknown |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit<br><input type="checkbox"/> Helmet<br><input type="checkbox"/> Laser protective visor/glasses<br><input type="checkbox"/> PLB<br><input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Night vision goggles<br><input type="checkbox"/> Helmet visor<br><input type="checkbox"/> Personal flotation<br><input type="checkbox"/> Other: _____ |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                                          |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                                                      | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><input type="checkbox"/> 5 under 1 years<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Child<br><input type="checkbox"/> Unknown |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit<br><input type="checkbox"/> Helmet<br><input type="checkbox"/> Laser protective visor/glasses<br><input type="checkbox"/> PLB<br><input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Night vision goggles<br><input type="checkbox"/> Helmet visor<br><input type="checkbox"/> Personal flotation<br><input type="checkbox"/> Other: _____ |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                                          |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ Zip: _____<br>Last name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                                                      | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown<br><input type="radio"/> Supplemental<br>Restraint type: _____ | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><input type="checkbox"/> 5 under 1 years<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Child<br><input type="checkbox"/> Unknown |
| <b>Personal Flight Equipment (Check all that apply)</b><br><input type="checkbox"/> Fire resistant flight suit<br><input type="checkbox"/> Helmet<br><input type="checkbox"/> Laser protective visor/glasses<br><input type="checkbox"/> PLB<br><input type="checkbox"/> Fire resistant gloves<br><input type="checkbox"/> Night vision goggles<br><input type="checkbox"/> Helmet visor<br><input type="checkbox"/> Personal flotation<br><input type="checkbox"/> Other: _____ |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                                          |

### FLIGHT ITINERARY INFORMATION

| Last Departure Point                                                                        | Time of Departure                          | Flight Information                                | Destination                                                                                 | Type Flight Plan Filed                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Airport ID: <u>MRI</u><br>City: <u>Anchorage</u><br>State: <u>AK</u><br>Country: <u>USA</u> | Time: <u>13:30</u><br>Time Zone: <u>AK</u> | Flight Number: _____<br>Operating as Flight _____ | Airport ID: <u>MRI</u><br>City: <u>Anchorage</u><br>State: <u>AK</u><br>Country: <u>USA</u> | <input type="radio"/> None<br><input type="radio"/> Company VFR<br><input type="radio"/> Military VFR<br><input checked="" type="radio"/> VFR<br><br>Activated? <input type="radio"/> Yes <input type="radio"/> No<br><input checked="" type="radio"/> Unknown |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Type of ATC Clearance/Service (Check all that apply)</b><br><input type="checkbox"/> Certificate of Authorization<br><input checked="" type="checkbox"/> VFR<br><input type="checkbox"/> Special VFR<br><input type="checkbox"/> IFR                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> None<br><input type="checkbox"/> Special IFR<br><input type="checkbox"/> VFR On Top                                                                                                                                              | <input type="checkbox"/> VFR Flight Following<br><input type="checkbox"/> Traffic Advisory                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Cruise<br><input type="checkbox"/> Unknown / NA                                                                                              |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Type of ATC Clearance/Service (Check all that apply)</b><br><input type="checkbox"/> Class A<br><input type="checkbox"/> Class B<br><input type="checkbox"/> Class C<br><input type="checkbox"/> Class D<br><input type="checkbox"/> Class E                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Class G<br><input type="checkbox"/> Demo Area<br><input type="checkbox"/> Warning Area<br><input type="checkbox"/> Prohibited Area<br><input type="checkbox"/> Restricted Area                                                   | <input type="checkbox"/> Military Operations Area (MOA)<br><input type="checkbox"/> Airport Advisory Area<br><input type="checkbox"/> Jet Training Area<br><input type="checkbox"/> TRSA<br><input type="checkbox"/> FAR 93                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Special Air Traffic Control Area<br><input type="checkbox"/> Unknown                                                                         | <b>Altitude of In-Flight Occurrence:</b><br>_____ ft.<br>MSL                                                                                                                                                                |                                                                                                                                                                          |
| <b>WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Source of Pilot Weather Information (Check all that apply)</b><br><input type="checkbox"/> National Weather Service<br><input type="checkbox"/> Flight Service Station<br><input type="checkbox"/> TV/Radio<br><input checked="" type="checkbox"/> Automated Report<br><input type="checkbox"/> Electronic Flight Bag-Application:<br><input type="checkbox"/> On-Board Weather                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                          | <input type="checkbox"/> Company<br><input type="checkbox"/> Military<br><input type="checkbox"/> Internet<br><input type="checkbox"/> None<br><input type="checkbox"/> Unknown                                                                                      | <b>Weather Observation Facility</b><br>Facility ID: <u>PAQ</u><br>Observation Time: <u>14:40</u><br>Time Zone: <u>AK</u><br>Distance from Accident Site: <u>10</u> nm<br>Direction from Accident Site: <u>270</u> degrees true                                                                                                                                                                                                                                                                                              |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Lowest Cloud Condition Height</b><br>_____ ft. AGL                                                                                                                                                                                    | <b>Light Condition</b><br><input type="radio"/> Dawn<br><input checked="" type="radio"/> Day<br><input type="radio"/> Dusk<br><input type="radio"/> Night<br><input type="radio"/> Dark Night<br><input type="radio"/> Bright Night<br><input type="radio"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Sky/Lowest Cloud Condition</b><br><input checked="" type="radio"/> Clear<br><input type="radio"/> Few<br><input type="radio"/> Partial<br><input type="radio"/> Obscuration<br><input type="radio"/> Scattered<br><input type="radio"/> Thin Broken<br><input type="radio"/> Thin Overcast<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                  | <b>Ceiling</b><br><input checked="" type="radio"/> None (Clear)<br><input type="radio"/> Broken<br><input type="radio"/> Overcast<br><input type="radio"/> Obscured<br><input type="radio"/> Indefinite<br><input type="radio"/> Unknown | <b>Ceiling Height</b><br>_____ ft. AGL                                                                                                                                                                                                                               | <b>Temperature:</b> _____ (°C) or <u>50</u> (°F)<br><b>Dewpoint:</b> _____ (°C) or <u>n/a</u> (°F)                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Altimeter Setting:</b> <u>2968</u> Hg<br>or _____ mb                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Wind Direction</b><br><input checked="" type="checkbox"/> Variable<br>or<br>Direction: _____ degrees true                                                                                                                             | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>or<br>Speed: <u>10</u> kts                                                                                                                                      | <b>Wind Gusts</b><br><input type="checkbox"/> Not Gusting<br>or<br>Speed: <u>10</u> kts                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Visibility</b><br><u>&gt;10</u> miles<br>RVR: _____ feet<br>RVV: _____ miles<br>Density Altitude: _____ ft.                                                        |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Type of Precipitation (Check all that apply)</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Rain<br><input type="checkbox"/> Snow<br><input type="checkbox"/> Hail<br><input type="checkbox"/> Rain Showers<br><input type="checkbox"/> Drizzle<br><input type="checkbox"/> Ice Pellets<br><input type="checkbox"/> Snow Pellets<br><input type="checkbox"/> Snow Grains<br><input type="checkbox"/> Ice Crystals<br><input type="checkbox"/> Freezing Rain<br><input type="checkbox"/> Snow Shower<br><input type="checkbox"/> Ice Pellets Shower<br><input type="checkbox"/> Freezing Drizzle |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      | <b>Restriction to Visibility (Check all that apply)</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Blowing Dust<br><input type="checkbox"/> Blowing Sand<br><input type="checkbox"/> Blowing Snow<br><input type="checkbox"/> Blowing Spray<br><input type="checkbox"/> Dust<br><input type="checkbox"/> Fog<br><input type="checkbox"/> Ground Fog<br><input type="checkbox"/> Haze<br><input type="checkbox"/> Ice Fog<br><input type="checkbox"/> Smoke<br><input type="checkbox"/> Unknown |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |
| <b>Iceing Forecast Amount</b><br><input checked="" type="radio"/> None<br><input type="radio"/> Trace<br><input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Severe<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                         | <b>Type</b><br><input type="radio"/> N/A<br><input type="radio"/> Rime<br><input type="radio"/> Clear<br><input type="radio"/> Mixed<br><input type="radio"/> Unknown                                                                    | <b>Intensity of Precipitation</b><br><input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Heavy<br><input type="radio"/> N/A<br><input type="radio"/> Unknown                                                                      | <b>Iceing Actual Amount</b><br><input checked="" type="radio"/> None<br><input type="radio"/> Trace<br><input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Severe<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                       | <b>Type</b><br><input type="radio"/> N/A<br><input type="radio"/> Rime<br><input type="radio"/> Clear<br><input type="radio"/> Mixed<br><input type="radio"/> Unknown | <b>Turbulence (Check all that apply)</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Clean Air<br><input checked="" type="checkbox"/> Terrain-Induced<br><input type="checkbox"/> Convective<br>Turbulence | <b>Severity</b><br><input type="checkbox"/> Light<br><input checked="" type="checkbox"/> Moderate<br><input type="checkbox"/> Severe<br><input type="checkbox"/> Extreme |
| <b>NOTAMs (D and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident:</b><br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                                                                                             |                                                                                                                                                                          |

**DAMAGE TO AIRCRAFT AND OTHER PROPERTY****Aircraft Damage**

- ☐ None  
☒ Minor  
☐ Substantial  
☐ Destroyed  
☐ Unknown

**Aircraft Fire**

- ☒ None  
☐ In-Flight  
☐ On-Ground  
☐ Both Ground and In-Flight  
☐ Fire at Unknown Time  
☐ Unknown

**Aircraft Explosion**

- ☒ None  
☐ In-Flight  
☐ On-Ground  
☐ Both Ground and In-Flight  
☐ Fire at Unknown Time  
☐ Unknown

**Description of Damage to Aircraft and Other Property** (Use additional sheet, if necessary.)

Damage to the rudder and right wing with prop strike.

**NARRATIVE HISTORY OF FLIGHT** (Please type or print in ink.)

Describe what occurred in chronological order, including circumstances leading to and nature of accident/incident. Describe terrain and include wreckage distribution sketch if pertinent. Attach extra sheets if needed. State departure time and location, services obtained, and intended destination. Provide as much detail as possible.

1. The left lower cargo door became loose and started banging 5 minutes before landing.
2. I previously had never landed on undesignated landing strips but elected to land on a gravel bar to close the cargo door fearing damage with continued buffeting.
3. I selected a safe appearing gravel bar on the Knik river and made 3 airborne passes to inspect it closely before landing.
4. I performed a landing but the brakes locked at the end of the ground role on a softer area of ground causing ground loop and flip.

**OPERATOR/OWNER SAFETY RECOMMENDATION** (How could this accident/incident have been prevented?)

I will never land again on an undesignated landing strip.

| <b>MECHANICAL MALFUNCTION/FAILURE</b> (If more space is needed, continue on a separate sheet.)                                                                                                                                                             |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Was there Mechanical Malfunction/Failure? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)                                        | <b>Total Time/ Cycles On Part</b><br>_____ Hours<br>_____ Cycles<br><br><b>Time Since This Part Inspected/Overhauled</b><br>_____ Hours                                                                                                      |                                                                                                                                                                             |
| <b>FUEL &amp; SERVICES INFORMATION</b>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
| <b>Fuel on Board at Last Takeoff</b><br>(Convert from pounds, as necessary)<br>39 _____ Gallons                                                                                                                                                            | <b>Fuel Type</b><br><input checked="" type="radio"/> 100 Low Lead <input type="radio"/> Jet A <input type="radio"/> Unleaded AV<br><input type="radio"/> Automotive <input type="radio"/> Jet A-1 <input type="radio"/> Other, specify _____ |                                                                                                                                                                             |
| Other Services, if any, prior to departure:                                                                                                                                                                                                                |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
| <b>EVACUATION OF AIRCRAFT</b>                                                                                                                                                                                                                              |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
| Was an emergency evacuation of the aircraft performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Method of Exit – Describe how the occupants exited and how many occupants evacuated each location:<br>Through the main door. |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
| <b>OTHER AIRCRAFT – COLLISION</b> (If air or ground collision occurred, complete this section for other aircraft.)                                                                                                                                         |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
| Aircraft Registration Number<br>_____                                                                                                                                                                                                                      | Manufacturer: _____<br>Model: _____                                                                                                                                                                                                          | <b>Damage to Other Aircraft:</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None |
| <b>Registered Owner of Other Aircraft</b><br>Name: _____<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                       |                                                                                                                                                                                                                                              | <b>Pilot of Other Aircraft</b><br>Name: _____<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                   |
| <b>ADDITIONAL INFORMATION</b> (Additional space for answers to any question.)                                                                                                                                                                              |                                                                                                                                                                                                                                              |                                                                                                                                                                             |
|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                              |                                                                                                                                                                             |

By signing this form, I am consenting to the public release of the information provided herein.

Date of this report:  
09/27/2024  
 mm/dd/yyyy

Name of Pilot/Operator: MARIUS MAXWELL

Signature: \_\_\_\_\_

-or- ☐ Check here to electronically sign this document

If a person other than Pilot/Operator is filing this report

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

-or- ☐ Check here to electronically sign this document

**FOR NTSB USE ONLY**

NTSB Accident/Incident No.  
 ANC24LA100

Reviewed by NTSB AS Division  
 Anchorage, AK

Name of Investigator  
 M. Rasmussen

Date Report Received  
 09/29/2024