

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

This form to be used for reporting civil and public aircraft accidents and incidents

## BASIC INFORMATION

### Accident/Incident Location

Nearest City/Place: Fairbanks State: Alaska

ZIP: 99712 Country: United States of America

Latitude: 64.8733363 Longitude: -147.0156832

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

### Accident/Incident Date/Time

Date: 6/13/2025 Local Time: 1615  
mm/dd/yyyy

Time Zone: Alaska

Collision with Other Aircraft: ☐ Midair ☐ On-ground ☒ None

## AIRCRAFT INFORMATION

Registration Number: N3846M

Manufacturer: Piper

Model: PA12

Serial Number: 12-2757

Year of Manufacture: 1946

Amateur-Built: ☒ Yes ☐ No If Yes: ☐ Kit/Plans ☐ Original Design Make: \_\_\_\_\_

☐ IFR-Equipped and Certified

☐ Commercial Space Flight

☐ Unmanned Aircraft

Maximum Gross Weight: 1750 lbs

Weight at Time of Accident/Incident: Approx. 1566 lbs

Number of Seats: 2 Flight Crew Seats: 1

Cabin Crew Seats: \_\_\_\_\_ Passenger Seats: 1

Number of Engines: 1

### Category of Aircraft

- ☒ 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

#### Special

- ☐ Restricted  
☐ Limited  
☐ Provisional  
☐ Special Flight  
☐ Experimental  
☐ Special Light-Sport  
☐ Experimental Light-Sport

☐ Certificate of Authorization or Waiver (COA)

☐ None

☐ Unknown

### Landing Gear

(Check all that apply)

☐ Retractable

☐ Tricycle

☐ Amphibian

☐ Emergency Float

☐ Float

☐ Hull

☐ Other Launch/Recovery System

☐ None

☒ Tailwheel

☐ High Skid

☐ Skid

☐ Ski

☐ Ski/Wheel

☐ Unknown

### Engine Type (Select one)

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

### Fuel System Type (Reciprocating)

☒ Carburetor ☐ Fuel-Injected

| Engine | Engine Manufacturer | Engine Model/Serial | Manufacturer's 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<br>(hours) | Overhaul<br>(hours) |
|--------|---------------------|---------------------|------------------------------|----------------------------|------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------|
| Eng. 1 | <u>Lycoming</u>     | <u>0-320-A2B</u>    | <u>L-10273-27</u>            |                            | <u>150</u>                                                                                           | <u>3575.3</u>         | <u>24.19</u>                         | <u>739.2</u>        |
| Eng. 2 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 3 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 4 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |

### Last Inspection Type

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

Date Last Inspection: 04/30/25

mm/dd/yyyy

Airframe Total Time: 4249.3 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: Handheld extinguisher

### Propeller 1

- ☒ Fixed Pitch  
☐ Controllable Pitch  
☐ Ground Adjustable

Manufacturer: McCauley

Model: 1A175

### Propeller 2

- ☐ Fixed Pitch  
☐ Controllable Pitch  
☐ Ground Adjustable

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

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

ELT Installed: ☒ Yes ☐ No

If Yes:

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

Model or Part No.: \_\_\_\_\_

TSO No.: ☐ OC91 (121.5 MHz) ☐ OC91a (121.5 MHz)  
☐ OC126 (406 MHz)

Was ELT still mounted in aircraft? ☒ Yes ☐ No

Was ELT still connected to antenna? ☒ Yes ☐ No

Did ELT Activate? ☐ Yes ☒ No

If activated:

Did ELT Aid in Locating Aircraft? ☐ Yes ☒ No

If not activated:

- Indicate Reason: ☐ Impact Damage  
☐ Fire Damage  
☐ Battery Expired/Damaged  
☒ Unknown

### Additional Equipment (Check all that apply)

- ☒ ADS-B  
☐ Airframe Parachute  
☐ Angle of Attack Indicator  
☐ Autopilot  
☐ Data Recorder  
☐ Electronic Flight Bag or Handheld Device  
☐ Electronic Multifunction Display  
☐ Electronic Primary Flight Display  
☒ Handheld GPS  
☐ Heads Up Display  
☐ Onboard Weather  
☐ Satellite Tracking Device  
☐ Stall Warning System  
☐ Video Recording Device  
☐ Other, Specify: \_\_\_\_\_

**OWNER/OPERATOR INFORMATION****Registered Aircraft Owner**Name: Joshua FischerCity: FairbanksFractional Ownership Aircraft: ☐ Yes ☒ NoState: Alaska ZIP: 99712Country: United States of America**Operator of Aircraft**☒ Same As Registered Owner☒ Same Address as Registered Owner

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

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

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

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

Air Carrier/Operator Designator (4 Character Code): \_\_\_\_\_

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 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 ☐ Unknown  
☐ 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

**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: Private Strip

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

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

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

Proximity to Airport: ☒ Off Airport/Airstrip ☐ On Airport/Airstrip ☐ N/AAirport Elevation: 620 ft. msl**Runway Information**Runway ID: 14/32 (L/R/C) Length: 550 ft Width: 60 ft**Runway/Landing Surface** (Check all that apply)

- ☐ Asphalt ☒ Grass/Turf ☐ Macadam ☐ Water  
☐ Concrete ☐ Gravel ☐ Metal/Wood  
☐ Dirt ☐ Ice ☐ Snow ☐ Unknown

**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 ☐ Aborted Landing (after touchdown)  
☐ Crosswind ☐ Unknown

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

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

**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

☒ 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: Joshua City of Residence: Fairbanks  
 Middle Initial: S State: Alaska ZIP: 99712  
 Last Name: Fischer Country: United States of America  
 Age at time of Accident/Incident: 41 Date of Birth:                      mm/dd/yyyy  
 Certificate Number:                     

| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input checked="" type="radio"/> Serious                                                                                                                                                                                                                                                                                           | <b>Seat Occupied</b><br><input type="radio"/> Left <input checked="" 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 style="width: 100%;"> <tr> <th style="text-align: left;">Available</th> <th style="text-align: left;">Used</th> </tr> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> None</td> </tr> <tr> <td><input checked="" type="radio"/> Lap only</td> <td><input checked="" 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 checked="" type="radio"/> Lap only | <input checked="" 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 checked="" 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 checked="" type="radio"/> Lap only                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" 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)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input checked="" 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>Medical Certificate</b><br><input type="radio"/> None <input checked="" 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>Principal Occupation</b><br><input type="radio"/> Pilot<br><input checked="" type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                | <b>Medical Certificate Validity</b><br><input checked="" 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><u>11/06/2023</u><br>mm/dd/yyyy |      |                            |                            |                                           |                                           |                               |                               |                               |                               |                               |                               |                               |                               |                                                                                                                                                                                                                                           |

### Medical Certificate Limitations

None

### Medical Certificate Special Issuance

Date of Last Flight Review  
 or Equivalent, Including  
 FAR 121/135 Checks: N/A  
 mm/dd/yyyy

### Flight Review Aircraft

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

|                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Airplane Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input checked="" 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)</b><br>(Check all that apply)<br><input checked="" 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)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift | <b>Instructor Rating(s)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Airplane Single-Engine <input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Airplane Multi-Engine <input type="checkbox"/> Helicopter<br><input type="checkbox"/> Gyroplane <input type="checkbox"/> Glider<br><input type="checkbox"/> Powered Lift <input type="checkbox"/> Sport |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Type Ratings

### Student Endorsements (Include dates)

| Flight Time (Enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |           | Rotorcraft | Glider | Lighter Than Air |
|-------------------------------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|-----------|------------|--------|------------------|
|                                                             |              |                   |                        |                      |       | Actual     | Simulated |            |        |                  |
| Total Time                                                  | 126          | 126               | 126                    |                      | 3     |            | 4         |            |        |                  |
| Pilot in Command (PIC)                                      | 90           | 90                | 90                     |                      |       |            |           |            |        |                  |
| Time as Instructor                                          | 0            |                   |                        |                      |       |            |           |            |        |                  |
| This Make/Model                                             |              |                   |                        |                      |       |            |           |            |        |                  |
| Last 90 Days                                                | 29           | 29                | 29                     |                      | 0     |            | 0         |            |        |                  |
| Last 30 Days                                                | 10           | 10                | 10                     |                      |       |            |           |            |        |                  |
| Last 24 Hours                                               | 0            | 0                 | 0                      |                      |       |            |           |            |        |                  |

☐ Pilot    ☐ Co-Pilot    ☐ Student Pilot    ☐ Flight Instructor    ☐ Check Pilot    ☐ Flight Engineer    ☐ Other Flight Crew

City of Residence:

State: ZIP:

Country:

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

Medical Certificate Limitations

|                    |                          |                      |                      |
|--------------------|--------------------------|----------------------|----------------------|
| Airplane Rating(s) | Other Aircraft Rating(s) | Instrument Rating(s) | Instructor Rating(s) |
|--------------------|--------------------------|----------------------|----------------------|

| Type Ratings | Student Endorsements ( <i>Include dates</i> ) |
|--------------|-----------------------------------------------|
|              |                                               |

|                                        |          |      |          |          |      |            |          |      |            |
|----------------------------------------|----------|------|----------|----------|------|------------|----------|------|------------|
| Flight Time (Enter appropriate number) | Altitude | Time | Airplane | Altitude | Time | Instrument | Altitude | Time | Instrument |
|----------------------------------------|----------|------|----------|----------|------|------------|----------|------|------------|

[illegible]

| ADDITIONAL FLIGHT CREWMEMBERS (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                   |  |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                          |                                                                                                                                                            | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                 | <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>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student               </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport               </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer               </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign               </div> </div> |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="flex: 1;"> <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               </div> <div style="flex: 1;"> <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               </div> </div> |                                                                                                                                                                                                                 | <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>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                   |  |
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                   |  |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                          |                                                                                                                                                            | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                 | <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>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student               </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport               </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer               </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign               </div> </div> |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="flex: 1;"> <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               </div> <div style="flex: 1;"> <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               </div> </div> |                                                                                                                                                                                                                 | <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>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                   |  |
| <b>Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | <b>Seat</b>                                                                                                                              | <b>Injury</b>                                                                                                                                              | <b>Restraint Type</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                 | <b>Inflatable Restraints</b>                                                                                                                                                                                                   | <b>Age</b>                                                                                                                                                        |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                       |  |  | <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                                                                                                                                                                                                                                                                                                                                                                                               | <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                       |  |  | <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                                                                                                                                                                                                                                                                                                                                                                                               | <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                       |  |  | <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                                                                                                                                                                                                                                                                                                                                                                                               | <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                       |  |  | <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                                                                                                                                                                                                                                                                                                                                                                                               | <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |

## FLIGHT ITINERARY INFORMATION

|                                                                                                                                                      |                                                                         |                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Last Departure Point</b><br>Airport ID: <u>95Z</u><br>City: <u>North Pole</u><br>State: <u>Alaska</u><br>Country: <u>United States of America</u> | <b>Time of Departure</b><br>Time: <u>1550</u><br>Time Zone: <u>AKDT</u> | <b>Destination</b><br>Airport ID: <u>Private</u><br>City: <u>Fairbanks</u><br>State: <u>Alaska</u><br>Country: <u>United States of America</u> | <b>Type Flight Plan Filed</b><br><input checked="" type="radio"/> None <input type="radio"/> VFR/IFR<br><input type="radio"/> Company VFR <input type="radio"/> IFR<br><input type="radio"/> Military VFR <input type="radio"/> Unknown<br><input type="radio"/> VFR<br>Activated? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------|
| <b>Type of ATC Clearance/Service (Check all that apply)</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Special VFR <input type="checkbox"/> Special IFR <input type="checkbox"/> VFR Flight Following <input type="checkbox"/> Cruise<br><input type="checkbox"/> VFR <input type="checkbox"/> IFR <input type="checkbox"/> VFR On Top <input type="checkbox"/> Traffic Advisory <input type="checkbox"/> Unknown / NA                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                               |
| <b>Airspace where the accident/incident occurred (Check all that apply)</b><br><input type="checkbox"/> Class A <input checked="" type="checkbox"/> Class G <input type="checkbox"/> Military Operations Area (MOA) <input type="checkbox"/> Special<br><input type="checkbox"/> Class B <input type="checkbox"/> Demo Area <input type="checkbox"/> Airport Advisory Area <input type="checkbox"/> Air Traffic Control Area<br><input type="checkbox"/> Class C <input type="checkbox"/> Warning Area <input type="checkbox"/> Jet Training Area <input type="checkbox"/> Unknown<br><input type="checkbox"/> Class D <input type="checkbox"/> Prohibited Area <input type="checkbox"/> TRSA<br><input type="checkbox"/> Class E <input type="checkbox"/> Restricted Area <input type="checkbox"/> FAR 93 |  |  | <b>Altitude of In-Flight Occurrence:</b><br><u>650</u> ft msl |

## WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE

| <b>Source of Pilot Weather Information (Check all that apply)</b><br><input checked="" type="checkbox"/> National Weather Service <input type="checkbox"/> Company<br><input type="checkbox"/> Flight Service Station <input type="checkbox"/> Military<br><input type="checkbox"/> TV/Radio <input type="checkbox"/> Internet<br><input checked="" type="checkbox"/> Automated Report <input type="checkbox"/> None<br><input type="checkbox"/> Commercial Weather Service (DUATS) <input type="checkbox"/> Unknown<br><input type="checkbox"/> On-Board Weather |                                   | <b>Weather Observation Facility</b><br>Facility ID: <u>PAEI</u><br>Observation Time: <u>1455</u><br>Time Zone: <u>AKDT</u><br>Distance from Accident Site: <u>13</u> nm<br>Direction from Accident Site: <u>355</u> degrees true                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------|----------|------------------------------------------|--------------------------------|------------------------------------|-----------------------------------|------------------------------------------|---------------------------------|------------------------------------------------|----------------------------------|------------------------------|-------------------------------|-------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------|------|---------------------------------------|---------------------------|-----------------------------|----------------------------|-----------------------------|-----------------------------|--------------------------------|-----------------------------|------------------------------|-------------------------------|-------------------------------|--|
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Sky/Lowest Cloud Condition</b><br><input type="radio"/> Clear <input type="radio"/> Thin Broken<br><input checked="" type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input type="radio"/> Unknown<br><input type="radio"/> Scattered<br><b>Lowest Cloud Condition Height</b><br><u>7000</u> ft agl                                                                                                                                                                                                        |                                   | <b>Ceiling</b><br><input type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input checked="" type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input type="radio"/> Unknown<br><b>Ceiling Height</b><br><u>25000</u> ft agl                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Wind Direction</b><br><input type="checkbox"/> Variable<br>-or-<br>Direction: <u>360</u> degrees true                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                   | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>-or-<br>Speed: <u>3</u> kts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Wind Gusts</b><br><input checked="" type="checkbox"/> Not Gusting<br>-or-<br>Speed: _____ kts |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Intensity of Precipitation</b><br><input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Heavy<br><input checked="" type="radio"/> N/A<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                        |                                   | <b>Type of Precipitation (Check all that apply)</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Drizzle <input type="checkbox"/> Freezing Rain<br><input type="checkbox"/> Rain <input type="checkbox"/> Ice Pellets <input type="checkbox"/> Snow Shower<br><input type="checkbox"/> Snow <input type="checkbox"/> Snow Pellets <input type="checkbox"/> Ice Pellets Shower<br><input type="checkbox"/> Hail <input type="checkbox"/> Snow Grains <input type="checkbox"/> Freezing Drizzle<br><input type="checkbox"/> Rain Showers <input type="checkbox"/> Ice Crystals            |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Restriction to Visibility (Check all that apply)</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Fog<br><input type="checkbox"/> Blowing Dust <input type="checkbox"/> Ground Fog<br><input type="checkbox"/> Blowing Sand <input type="checkbox"/> Haze<br><input type="checkbox"/> Blowing Snow <input type="checkbox"/> Ice Fog<br><input type="checkbox"/> Blowing Spray <input type="checkbox"/> Smoke<br><input type="checkbox"/> Dust <input type="checkbox"/> Unknown                                                         |                                   | <b>Temperature:</b> <u>24</u> (C) or _____ (F)<br><b>Dew Point:</b> _____ (C) or _____ (F)<br><b>Altimeter Setting:</b> <u>29.93</u> in. Hg<br>or _____ MB                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Visibility</b> <u>10</u> miles<br>RVR: _____ feet<br>RVV: _____ miles<br><b>Density Altitude:</b> _____ ft                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | <b>Icing Forecast</b><br><table border="0"> <tr> <th>Amount</th> <th>Type</th> </tr> <tr> <td><input checked="" type="radio"/> None</td> <td><input type="radio"/> N/A</td> </tr> <tr> <td><input type="radio"/> Trace</td> <td><input type="radio"/> Rime</td> </tr> <tr> <td><input type="radio"/> Light</td> <td><input type="radio"/> Clear</td> </tr> <tr> <td><input type="radio"/> Moderate</td> <td><input type="radio"/> Mixed</td> </tr> <tr> <td><input type="radio"/> Severe</td> <td><input type="radio"/> Unknown</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td></td> </tr> </table> |                                                                                                  | Amount                      | Type     | <input checked="" type="radio"/> None    | <input type="radio"/> N/A      | <input type="radio"/> Trace        | <input type="radio"/> Rime        | <input type="radio"/> Light              | <input type="radio"/> Clear     | <input type="radio"/> Moderate                 | <input type="radio"/> Mixed      | <input type="radio"/> Severe | <input type="radio"/> Unknown | <input type="radio"/> Unknown |  | <b>Icing Actual</b><br><table border="0"> <tr> <th>Amount</th> <th>Type</th> </tr> <tr> <td><input checked="" type="radio"/> None</td> <td><input type="radio"/> N/A</td> </tr> <tr> <td><input type="radio"/> Trace</td> <td><input type="radio"/> Rime</td> </tr> <tr> <td><input type="radio"/> Light</td> <td><input type="radio"/> Clear</td> </tr> <tr> <td><input type="radio"/> Moderate</td> <td><input type="radio"/> Mixed</td> </tr> <tr> <td><input type="radio"/> Severe</td> <td><input type="radio"/> Unknown</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td></td> </tr> </table> |  | Amount | Type | <input checked="" type="radio"/> None | <input type="radio"/> N/A | <input type="radio"/> Trace | <input type="radio"/> Rime | <input type="radio"/> Light | <input type="radio"/> Clear | <input type="radio"/> Moderate | <input type="radio"/> Mixed | <input type="radio"/> Severe | <input type="radio"/> Unknown | <input type="radio"/> Unknown |  |
| Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Type                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input checked="" type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> N/A         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Trace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Rime        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Light                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Clear       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> Mixed       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Severe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Unknown     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Type                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input checked="" type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> N/A         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Trace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Rime        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Light                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Clear       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> Mixed       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Severe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Unknown     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <b>Turbulence</b><br><table border="0"> <tr> <th>Type (Check all that apply)</th> <th>Severity</th> </tr> <tr> <td><input checked="" type="checkbox"/> None</td> <td><input type="checkbox"/> Light</td> </tr> <tr> <td><input type="checkbox"/> Clear Air</td> <td><input type="checkbox"/> Moderate</td> </tr> <tr> <td><input type="checkbox"/> Terrain-Induced</td> <td><input type="checkbox"/> Severe</td> </tr> <tr> <td><input type="checkbox"/> Convective Turbulence</td> <td><input type="checkbox"/> Extreme</td> </tr> </table>                      |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | Type (Check all that apply) | Severity | <input checked="" type="checkbox"/> None | <input type="checkbox"/> Light | <input type="checkbox"/> Clear Air | <input type="checkbox"/> Moderate | <input type="checkbox"/> Terrain-Induced | <input type="checkbox"/> Severe | <input type="checkbox"/> Convective Turbulence | <input type="checkbox"/> Extreme |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| Type (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Severity                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input checked="" type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Light    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="checkbox"/> Clear Air                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Moderate |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="checkbox"/> Terrain-Induced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Severe   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |
| <input type="checkbox"/> Convective Turbulence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Extreme  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |        |      |                                       |                           |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |

NOTAMs (D and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident:

None known

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

- ☐ None      ☒ Substantial  
☐ Minor      ☐ Destroyed  
                 ☐ Unknown

**Aircraft Fire**

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

**Aircraft Explosion**

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

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

Damage to cabin forward portion of fuselage from ground impact and EMS extraction  
Damage to left and right wings  
Prop damage  
Damage to landing Gear

**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.

Approximately 1515 AKDT, June 13, 2025 I arrived at Bradley Sky Ranch (95Z) for a solo flight to a private strip at my residence. I added 5 gallons of fuel to my right fuel tank from a gas jug, using my external water separator filter. I parked my pickup, check weather and NOTAMs using foreflight and proceeded to preflight my aircraft. I opened cabin door, turned both fuel selectors on, placed my key on the "dash" below the windscreen, and plugged in my headset. I retrieved my fuel tester from behind the pilot seat, sumped the right wing, gascolator and attempted to sump left wing fuel tank, but was unable to get the left wing sump to actuate. I completed my preflight, checking engine oil, engine mounting, mag, spark plugs, oil cooler, fuel lines, carburetor, prop, landing gear assemblies, wing structures, flaps, ailerons, fuselage, tail flight control assemblies, tail wheel, etc. I climbed in the front seat, went through start up procedure, and started the aircraft engine. I allowed engine to warm up for a few minutes and proceeded to taxi for a runway 15 departure. I performed a mag ground check and mixture cut off while taxiing. I performed a run-up (mag check, carb heat, as well as a flight control function check) before proceeding to take off on runway 15. I took off and stayed in the pattern for runway 15 performing two landings to a full stop with subsequent takeoffs. After the second landing and takeoff, I departed straight out and proceeded to the Northeast towards my house. I flew directly to the area of my residence, noting indicated airspeed, ground speed as indicated on my GPS, and wind direction as indicated on waterbodies along my route. I noted the wind to be from the west. The flight was uneventful. I turned for a 2 mile final in a NNW direction to the strip at my house and announced my intentions on CTAF 122.8 and a locally used channel 123.45. As I approached on final I didn't feel stabilized to the point of committing to landing, so I initiated a go around. I made a lap utilizing left traffic and came on final approach about 1 mile out on a NNW heading to my 550' grass strip at my house. My windsock was indicating variable winds from left cross wind to a tail wind. I didn't like how my approach was looking so I initiated another go around. I applied full throttle and began to climb. My climb rate was not what I felt was needed to clear the obstacles at the north end of my runway. I made a slight left bank but went back to straight out climb flight because I felt that the plane was close to imminent stall in the slight bank. I continued to climb straight out attempting to clear the obstacles. My left wing strut failed to clear the trees. When contact was made the aircraft spun roughly 90° putting me on a south heading. I looked out to my left wing and saw it still intact but the struts were damaged. I maintained level flight for a few seconds. I made the decision to attempt to get back to the field adjacent to my strip, which was east of my position. Before I could make that left turn, I suddenly lost forward travel speed. I did not see what caused forward travel suddenly to cease. The aircraft turned left and nose down and impacted the terrain. The engine was still under full power and the prop struck trees as the aircraft went down. I never lost consciousness. After impact, I call EMS, at 1615 AKDT, and requested medical assistance. I shut off my fuel valves, key, and master switch while on still on the phone with EMS dispatch.

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

Operator/Owner Safety Recommendation

Incident could have been prevented by pilot choosing not to attempt to land at short private strip in given meteorological conditions.

Density Altitude decreased aircraft performance. Tail wind on approach contributed to poor climb out after go around initiated. Be aware of the affects of these conditions on aircraft performance.

Utilize longer runways. Construction facilitating increased available landing strip length at this location

**MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)**Was there Mechanical Malfunction/Failure? ☐ Yes ☒ No  
(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)Total Time/Cycles  
On Part

\_\_\_\_\_ Hours

\_\_\_\_\_ Cycles

Time Since This Part  
Inspected/Overhauled

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**Fuel on Board at Last Takeoff  
(Convert from pounds, as necessary)24 Gallons

Fuel Type

☐ 80/87      ☐ 115/145      ☐ Jet B      ☒ Other, specify 40/60 mix 100LL/90  
☐ 100 Low Lead      ☐ Jet A      ☐ JP8  
☐ 100/130      ☐ Jet A-1      ☐ Automotive

Other Services, if Any, Prior to Departure

Foreflight for Metar at PAEI, and PAFA, and NOTAMs

**EVACUATION OF AIRCRAFT**Was an emergency evacuation of the aircraft performed? ☐ Yes ☒ No

Method of Exit – Describe how the occupants exited and how many occupants evacuated each location

Pilot was pinned in cockpit and had to be extracated by EMS personnel. Fuselage was cut in multiple areas to facilitate extraction.

**OTHER AIRCRAFT – COLLISION (If air or ground collision occurred, complete this section for other aircraft)**

Aircraft Registration Number

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

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

Damage to Other Aircraft

☐ Destroyed      ☐ Minor  
☐ Substantial      ☐ None

Registered Owner of Other Aircraft

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

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

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

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

Pilot of Other Aircraft

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

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

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

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

**ADDITIONAL INFORMATION** (Please type or print in ink)

Use this space if additional space is needed for any answers.

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE**

Date of this Report

06/17/2025

*mm/dd/yyyy*

Name of Pilot/Operator: Joshua Fischer

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

-- or -- ☒ Check here to electronically sign this document

**If a Person Other than Pilot/Operator is Filing Report**

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

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

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

-- or -- ☐ Check here to electronically sign this document

**FOR NTSB USE ONLY**

NTSB Accident/Incident No.

ANC25LA051

Reviewed by NTSB Regional Office

AS-ANC

Name of Investigator

S. Joyce

Date Report Received

06/17/2025