

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

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

## BASIC INFORMATION

|                                                                                                                                                                                                                                    |                                                                                                                |
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| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>Grand Island</u> State: <u>NE</u><br>ZIP: <u>68801</u> Country: <u>USA</u><br>Latitude: <u>40:50:03 N</u> (dd:mm:ss N/S) Longitude: <u>098:18:34 W</u> (ddd:mm:ss E/W) | <b>Date/Time</b><br>Date: <u>02/13/2013</u> Local Time: <u>1430</u><br><u>mm/dd/yyyy</u> Time Zone: <u>CST</u> |
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| <b>Phase of Operation</b><br><input checked="" type="checkbox"/> Standing <input type="checkbox"/> Takeoff (incl. initial climb) <input type="checkbox"/> Cruise <input type="checkbox"/> Hover<br><input type="checkbox"/> Taxi <input type="checkbox"/> Climb <input type="checkbox"/> Maneuvering <input type="checkbox"/> Other<br><input type="checkbox"/> Descent <input type="checkbox"/> Landing <input type="checkbox"/> Approach <input type="checkbox"/> Unknown | <b>Collision with Other Aircraft</b><br><input type="checkbox"/> Midair<br><input type="checkbox"/> On-ground<br><input checked="" type="checkbox"/> None | <b>Altitude of In-Flight Occurrence</b><br><br>_____ ft MSL |
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## AIRCRAFT INFORMATION

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| <b>Manufacturer:</b> <u>Piper</u><br><b>Model:</b> <u>PA46-500TP</u><br><b>Serial Number:</b> <u>4697216</u><br><b>Registration Number:</b> <u>N32CA</u> Amateur-built: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <b>Max Gross Weight:</b> <u>5092</u> lbs<br><b>Weight at Time of Accident/Incident:</b> <u>4535</u> lbs<br><b>Location of Center of Gravity at Time of Accident/Incident:</b><br><u>142.62</u> inches from <input type="checkbox"/> nose or <input checked="" type="checkbox"/> datum<br>-or- _____ Percent Mean Aerodynamic Cord (% MAC) |
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| <b>Category of Aircraft</b><br><input checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Blimp/Dirigible<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyrocraft<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered lift<br><input type="checkbox"/> Ultralight<br><input type="checkbox"/> Unknown | <b>Type of Airworthiness Certificate</b><br><i>(Check all that apply)</i><br><b>Standard</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Utility<br><input type="checkbox"/> Acrobatic<br><input type="checkbox"/> Transport<br><b>Special</b><br><input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Experimental<br><input type="checkbox"/> Special Flight<br><input type="checkbox"/> Light Sport | <b>Number of Seats:</b> <u>6</u><br>If Large Aircraft, how many seats for:<br>Flight Crew: _____<br>Cabin Crew: _____<br>Passengers: _____ | <b>Landing Gear</b> <input checked="" type="checkbox"/> Retractable<br>Check any additional landing gear configuration that applies:<br><input checked="" type="checkbox"/> Tricycle <input type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Unknown |
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| <b>Type of Maintenance Program</b><br><input checked="" type="checkbox"/> Annual<br><input type="checkbox"/> Conditional (Amateur-built only)<br><input type="checkbox"/> Manufacturer's Inspection Program<br><input type="checkbox"/> Other Approved Inspection Program (AAIP)<br><input type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> Other, specify: _____ | <b>Last Inspection Type</b><br><input type="checkbox"/> 100 Hour <input type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> AAIP <input type="checkbox"/> Conditional Inspection<br><input checked="" type="checkbox"/> Annual <input type="checkbox"/> Unknown | <b>Date Last Inspection:</b> <u>02/12/2013</u><br><u>mm/dd/yyyy</u><br><b>Airframe Total Time:</b> <u>1332</u> hrs<br>hours measured at (check one)<br><input checked="" type="checkbox"/> Last Inspection <input type="checkbox"/> Time of Accident/Incident |
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| <b>IFR Equipped</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <b>Stall Warning System Installed</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <b>Type of Fire Extinguishing System</b><br><input type="checkbox"/> None   Portable extinguisher<br><input checked="" type="checkbox"/> Specify _____ |
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|                                                                                                                                                                                      |                                                                                                                                                           |
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| <b>ELT Installed</b> <b>ELT Activated</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <b>ELT Manufacturer:</b> _____<br><b>Model/Series:</b> _____<br><b>Serial Number:</b> _____<br><b>Battery Type:</b> _____ <b>Battery Exp. Date:</b> _____ |
| <b>ELT Aided in Locating Accident/Incident</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                |                                                                                                                                                           |

|                                                                                                                                                                                                                                                               |                                                                                                                        |                                                                                                                                                                             |
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| <b>Engine Type</b><br><input type="checkbox"/> Reciprocating <input type="checkbox"/> Turbo Jet<br><input type="checkbox"/> Turbo Shaft <input type="checkbox"/> Turbo Fan<br><input checked="" type="checkbox"/> Turbo Prop <input type="checkbox"/> Unknown | <b>Reciprocating Fuel System Type</b><br><input type="checkbox"/> Carburetor<br><input type="checkbox"/> Fuel Injected | <b>Propeller</b><br><input type="checkbox"/> Fixed Pitch <input checked="" type="checkbox"/> Controllable Pitch<br>Manufacturer: <u>Hartzell</u><br>Model: <u>HC-E4N-3Q</u> |
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| Engine | Engine Manufacturer    | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br><i>mm/dd/yyyy</i> | Engine Rated Power Measured as (check one)<br><input checked="" type="checkbox"/> Horsepower or<br><input type="checkbox"/> lbs of Thrust | Total Time (hours) | Time Since Inspection (hours) | Time Since Overhaul (hours) |
|--------|------------------------|---------------------|------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------|-----------------------------|
| Eng. 1 | Pratt & Whitney Canada | PT6A-42A            | OCE-RM0235                   | 05/2005                           | 500 shp                                                                                                                                   | 1332               | 162                           |                             |
| Eng. 2 |                        |                     |                              |                                   |                                                                                                                                           |                    |                               |                             |
| Eng. 3 |                        |                     |                              |                                   |                                                                                                                                           |                    |                               |                             |
| Eng. 4 |                        |                     |                              |                                   |                                                                                                                                           |                    |                               |                             |

| <b>OWNER/OPERATOR INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
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| <b>Registered Aircraft Owner</b><br>Name: <u>Croft Aviation LLC</u><br><br>Fractional Ownership Aircraft: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                     | <b>Owner Address</b><br>City: <u>Westminster</u><br>State: <u>CO</u> ZIP: <u>80031</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                            |
| <b>Operator of Aircraft</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>Name: <u>Larry C Munch</u><br>Doing Business As: _____<br>Air Carrier/Operator Designator (4 Character Code): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                     | <b>Operator Address</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                            |
| <b>Regulation Flight Conducted Under</b><br><input checked="" type="checkbox"/> FAR 91 <input type="checkbox"/> FAR 129 <input type="checkbox"/> FAR 91 Special Flight <input type="checkbox"/> Public Use (select type)<br><input type="checkbox"/> FAR 103 <input type="checkbox"/> FAR 133 <input type="checkbox"/> Non-US, Commercial <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local<br><input type="checkbox"/> FAR 121 <input type="checkbox"/> FAR 135 <input type="checkbox"/> Non-US, Non-commercial <input type="checkbox"/> Unknown<br><input type="checkbox"/> FAR 125 <input type="checkbox"/> FAR 137 <input type="checkbox"/> Armed Forces |                                                                                                                                                                                                                                                                                                     | <b>Revenue Sightseeing Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br><b>Air Medical Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                            |
| <b>Purpose of Flight</b><br>for FAR 91, 103, 133, 137 (Select one)<br><br><input checked="" type="checkbox"/> Personal<br><input type="checkbox"/> Business<br><input type="checkbox"/> Executive/Corporate<br><input type="checkbox"/> Other Work Use<br><input type="checkbox"/> Instructional<br><input type="checkbox"/> Ferry<br><input type="checkbox"/> Positioning<br><input type="checkbox"/> Aerial Application<br><input type="checkbox"/> Aerial Observation<br><input type="checkbox"/> Air Drop<br><input type="checkbox"/> Air Race / Show<br><input type="checkbox"/> Flight Test<br><input type="checkbox"/> Public Use<br><input type="checkbox"/> Unknown                              | <b>Revenue Operation</b><br>for FAR 121, 125, 129, 135 (Select one)<br><br><input type="checkbox"/> Scheduled or Commuter<br><input type="checkbox"/> Non-Scheduled or Air Taxi<br><br><b>Domestic or International</b><br><input type="checkbox"/> Domestic <input type="checkbox"/> International | <b>Type of Commercial Operating Certificate Held</b><br>(Select all that apply)<br><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (129)<br><input type="checkbox"/> Commuter Air Carrier (135)<br><input type="checkbox"/> On-Demand Air Taxi (135)<br><input type="checkbox"/> Large Helicopter (127)<br><br><input type="checkbox"/> Rotorcraft External Load (133)<br>- or -<br><input type="checkbox"/> Agricultural Aircraft (137)<br><br><input type="checkbox"/> Other Operator of Large Aircraft |                                                                                                                                                                            |
| <b>OTHER AIRCRAFT – COLLISION</b> (If air or ground collision occurred, complete this section for other aircraft)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
| <b>Aircraft Registration Number</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Manufacturer:</b> _____<br><b>Model:</b> _____                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Damage to Other Aircraft</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None |
| <b>Registered Owner of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
| <b>Pilot of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
| <b>MECHANICAL MALFUNCTION/FAILURE</b> (If more space is needed, continue on separate sheet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
| <b>Was there Mechanical Malfunction/Failure?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)<br>Brakes did not hold aircraft in static position after engine startup.                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Total Time/Cycles On Part</b><br><br>_____ Hours<br>_____ Cycles<br><br><b>Time Since This Part Inspected/Overhauled</b><br>_____ 3 _____ Hours                         |
| <b>DAMAGE TO AIRCRAFT AND OTHER PROPERTY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                            |
| <b>Aircraft Damage</b><br><input type="checkbox"/> None <input checked="" type="checkbox"/> Substantial<br><input type="checkbox"/> Minor <input type="checkbox"/> Destroyed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Aircraft Fire</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                             | <b>Aircraft Explosion</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                            |

**Description of Damage to Aircraft and Other Property** (use additional sheet if necessary)  
Aircraft suffered damage to left wing and prop. Building suffered minimal damage.

**AIRPORT INFORMATION** (If the accident/incident occurred on approach, takeoff or within 3 miles of an airport, complete this section)

**Airport Identifier:** KGRI **Distance From Airport Center:** 0 SM  
**Airport Name:** Central Nebraska Regional Airport **Direction From Airport:** 0 degrees MAG  
**Proximity to Airport** ☐ Off Airport/Airstrip ☒ On Airport ☐ On Airstrip **Airport Elevation:** 1847 ft. MSL

**Approach Segment** (Select one)

☐ On Instrument Approach ☐ Landing ☐ Base leg ☐ Final ☐ Go Around  
☐ Crosswind ☐ Downwind ☐ Low Approach ☐ Aborted Landing (after touchdown)

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

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

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

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

**Runway Information**

Runway ID: (L/R/C) Length: ft Width: ft

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

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

**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 ☐ Unknown  
☐ Slush Covered ☐ Vegetation

**FLIGHT ITINERARY INFORMATION**

| Last Departure Point                                           | Time of Departure            | Destination                                                         | Type Flight Plan Filed                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------|------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Airport ID: KMDW<br>City: Chicago<br>State: IL<br>Country: USA | Time: 1151<br>Time Zone: CST | Airport ID: KGRI<br>City: Grand Island<br>State: NE<br>Country: USA | <input type="checkbox"/> None <input type="checkbox"/> VFR/IFR<br><input type="checkbox"/> Company VFR <input checked="" type="checkbox"/> IFR<br><input type="checkbox"/> Military VFR <input type="checkbox"/> Unknown<br><input type="checkbox"/> VFR<br>Activated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

**Type of ATC Clearance/Service** (Check all that apply)

☐ None ☐ Special VFR ☐ Special IFR ☐ VFR Flight Following ☐ Cruise  
☐ VFR ☒ IFR ☐ VFR On Top ☐ Traffic Advisory ☒ Unknown / NA

**Airspace where the accident/incident occurred** (Check all that apply)

☐ Class A ☐ Class E ☐ Prohibited Area ☐ Jet Training Area ☐ Special  
☐ Class B ☐ Class G ☐ Restricted Area ☐ TRSA ☐ Air Traffic Control Area  
☐ Class C ☐ Demo Area ☐ Military Operations Area (MOA) ☐ FAR 93 ☐ Unknown  
☐ Class D ☐ Warning Area ☐ Airport Advisory Area

**Aircraft Load Description** (Check all that apply)

☒ None ☐ Parachutists ☐ Livestock  
☐ Passengers ☐ Towing Glider ☐ Water ☐ Unknown  
☐ Cargo ☐ Towing Banner ☐ Chemical/Fertilizer/Seeds  
☐ Other External

**FUEL & SERVICES INFORMATION**

| Fuel on Board at Last Takeoff<br>(convert from pounds, as necessary) | Fuel Type                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 165 Gallons                                                          | <input type="checkbox"/> 80/87 <input type="checkbox"/> 115/145 <input type="checkbox"/> JP3 <input type="checkbox"/> Other, specify _____<br><input type="checkbox"/> 100 Low Lead <input checked="" type="checkbox"/> Jet A <input type="checkbox"/> JP4<br><input type="checkbox"/> 100/130 <input type="checkbox"/> Automotive <input type="checkbox"/> JP5 |

**Other Services, if Any, Prior to Departure**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>EVACUATION OF AIRCRAFT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>Was an emergency evacuation of the aircraft performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>Method of Exit</b> – Describe how the occupants exited and how many occupants evacuated each location<br><br><br>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>Weather Observation Facility</b><br>Facility ID: <u>KGRI</u><br>Observation Time: <u>1350</u><br>Time Zone: <u>CST</u><br>Distance from Accident Site: <u>0</u> NM<br>Direction from Accident Site: <u>0</u> degrees MAG                                                                                                                                                                                                                                                 |  | <b>Source of Weather Information</b><br><i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> National Weather Service<br/> <input type="checkbox"/> Flight Service Station<br/> <input type="checkbox"/> TV/Radio<br/> <input checked="" type="checkbox"/> Automated Report<br/> <input type="checkbox"/> Commercial Weather Service (DUATS)         </div> <div> <input type="checkbox"/> Company<br/> <input type="checkbox"/> Military<br/> <input type="checkbox"/> Internet<br/> <input type="checkbox"/> Unknown         </div> </div>                                                                                                                                                      |  |
| <b>Briefing Type/Completeness</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Full<br/> <input type="checkbox"/> Partial / Limited By Pilot<br/> <input type="checkbox"/> Partial / Limited By Briefer         </div> <div> <input type="checkbox"/> Abbreviated<br/> <input type="checkbox"/> Unknown<br/> <input checked="" type="checkbox"/> Not Pertinent         </div> </div>                                      |  | <b>Light Condition</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Dawn<br/> <input checked="" type="checkbox"/> Day         </div> <div> <input type="checkbox"/> Dusk<br/> <input type="checkbox"/> Night         </div> <div> <input type="checkbox"/> Dark Night<br/> <input type="checkbox"/> Bright Night<br/> <input type="checkbox"/> Not Reported         </div> </div>                                                                                                                                                                                                                                                                                                                                       |  |
| <b>Sky/Lowest Cloud Condition</b><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Clear<br/> <input type="checkbox"/> Few<br/> <input type="checkbox"/> Partial Obscuration<br/> <input type="checkbox"/> Scattered         </div> <div> <input type="checkbox"/> Thin Broken<br/> <input type="checkbox"/> Thin Overcast<br/> <input type="checkbox"/> Unknown         </div> </div>                             |  | <b>Ceiling</b><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> None (clear)<br/> <input type="checkbox"/> Broken<br/> <input type="checkbox"/> Overcast         </div> <div> <input type="checkbox"/> Obscured<br/> <input type="checkbox"/> Indefinite<br/> <input type="checkbox"/> Unknown         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>Lowest Cloud Condition Height</b><br><u>                    </u> ft AGL                                                                                                                                                                                                                                                                                                                                                                                                  |  | <b>Ceiling Height</b><br><u>                    </u> ft AGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>Wind Direction</b><br><input type="checkbox"/> Indicated:<br><u>                    </u> degrees MAG<br><br><input checked="" type="checkbox"/> Variable                                                                                                                                                                                                                                                                                                                 |  | <b>Wind Speed</b><br>Velocity: <u>          </u> KTS<br>-or-<br><input type="checkbox"/> Calm<br><input checked="" type="checkbox"/> Light and Variable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>Wind Gusts</b><br>Velocity: <u>          </u> KTS<br><br><input type="checkbox"/> Gusting<br><input checked="" type="checkbox"/> Not Gusting                                                                                                                                                                                                                                                                                                                             |  | <b>Type of Turbulence</b> <i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Clear Air         </div> <div> <input type="checkbox"/> In Clouds<br/> <input type="checkbox"/> Vicinity of Thunderstorm         </div> </div> <b>Severity of Turbulence</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Extreme<br/> <input type="checkbox"/> Severe         </div> <div> <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Moderate Chop         </div> <div> <input type="checkbox"/> Light         </div> </div>                                                                |  |
| <b>NOTAMs (D, L and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident</b><br><br><br>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>Temperature:</b> <u>          </u> (C)<br>or <u>          </u> (F)<br><br><b>Altimeter Setting:</b> <u>          </u> in. HG<br>or <u>          </u> MB<br><br><b>Density Altitude:</b> <u>          </u> ft<br><br><b>Dew Point:</b> <u>          </u> (C)<br>or <u>          </u> (F)                                                                                                                                                                                  |  | <b>Icing Forecast</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>Amount</b><br/> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Trace<br/> <input type="checkbox"/> Light<br/> <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Severe         </div> <div> <b>Type</b><br/> <input type="checkbox"/> Rime<br/> <input type="checkbox"/> Clear<br/> <input type="checkbox"/> Mixed         </div> </div>                                                                                                                                                                                                                                                                                             |  |
| <b>Icing Actual</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>Amount</b><br/> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Trace<br/> <input type="checkbox"/> Light<br/> <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Severe         </div> <div> <b>Type</b><br/> <input type="checkbox"/> Rime<br/> <input type="checkbox"/> Clear<br/> <input type="checkbox"/> Mixed         </div> </div> |  | <b>Type of Precipitation</b> <i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Rain<br/> <input type="checkbox"/> Snow<br/> <input type="checkbox"/> Hail<br/> <input type="checkbox"/> Rain Showers<br/> <input type="checkbox"/> Freezing Rain<br/> <input type="checkbox"/> Snow Shower         </div> <div> <input type="checkbox"/> Drizzle<br/> <input type="checkbox"/> Ice Pellets<br/> <input type="checkbox"/> Snow Pellets<br/> <input type="checkbox"/> Snow Grains<br/> <input type="checkbox"/> Ice Crystals<br/> <input type="checkbox"/> Ice Pellets Shower<br/> <input type="checkbox"/> Freezing Drizzle         </div> </div> |  |
| <b>Intensity of Precipitation</b><br><input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |

| <b>PILOT "A" INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
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| <b>Pilot "A" Responsibilities at the Time of Accident/Incident</b><br><input checked="" type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Pilot "A" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: <u>Larry</u><br/>           Middle Initial: <u>G</u><br/>           Last Name: <u>Munch</u> </div> <div>           City: <u>Westminster</u><br/>           State: <u>CO</u>    ZIP: <u>80031</u><br/>           Country: <u>USA</u> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Age at time of Accident/Incident: <u>57</u></div> <div>Date of Birth: <span style="background-color: black; color: black;">[REDACTED]</span><br/><small>mm/dd/yyyy</small></div> <div>Certificate Number: <span style="background-color: black; color: black;">[REDACTED]</span></div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                                    | <b>Seat Occupied</b><br><input checked="" type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | <b>Seat Belt</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                                               | <b>Shoulder Harness</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None    <input type="checkbox"/> Student<br/> <input type="checkbox"/> Private    <input type="checkbox"/> Flight Instructor           </div> <div> <input type="checkbox"/> Recreational    <input checked="" type="checkbox"/> Commercial<br/> <input type="checkbox"/> Sport    <input type="checkbox"/> Airline Transport           </div> <div> <input type="checkbox"/> Flight Engineer    <input type="checkbox"/> Foreign<br/> <input type="checkbox"/> U.S. Military           </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="checkbox"/> Pilot<br><input checked="" type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input type="checkbox"/> Class 3<br><input type="checkbox"/> Class 1 <input type="checkbox"/> Driver's License (Sport Pilot only)<br><input checked="" type="checkbox"/> Class 2 <input type="checkbox"/> Unknown                                                                      |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               | <b>Medical Certificate Validity</b><br><input type="checkbox"/> Without limitations/waivers<br><input checked="" type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           | <b>Date of Last Medical</b><br><u>06/27/2012</u><br><small>mm/dd/yyyy</small> |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b><br>Must wear corrective lenses, possess glasses for near/intermediate vision.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Medical Certificate Waivers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>05/12/2012</u><br><small>mm/dd/yyyy</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     | <b>Flight Review Aircraft</b><br>Make: <u>Piper</u><br>Model: <u>PA46T</u>                                                                                                                                                    |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><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><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Free 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><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                                 | <b>Instructor Rating(s)</b><br><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><div style="display: flex; justify-content: flex-end; margin-top: 5px;"> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport           </div> |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | <b>Student Endorsements</b> <i>(Include dates)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;"><b>Flight Time</b> <i>(enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 5px;">Total Time</td> <td>1931</td> <td>169</td> <td>1931</td> <td></td> <td>191</td> <td>215</td> <td>36</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Pilot in Command (PIC)</td> <td>1801</td> <td>169</td> <td>1801</td> <td></td> <td>191</td> <td>215</td> <td>36</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Time as Instructor</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">This Make/Model</td> <td colspan="10" style="background-color: black;"></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 90 Days</td> <td>21</td> <td>21</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 30 Days</td> <td>21</td> <td>21</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 24 Hours</td> <td>3</td> <td>3</td> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  | <b>Flight Time</b> <i>(enter appropriate number of hours in each box)</i> | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time | 1931 | 169 | 1931 |  | 191 | 215 | 36 |  |  |  | Pilot in Command (PIC) | 1801 | 169 | 1801 |  | 191 | 215 | 36 |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days | 21 | 21 | 21 |  |  |  |  |  |  |  | Last 30 Days | 21 | 21 | 21 |  |  |  |  |  |  |  | Last 24 Hours | 3 | 3 | 3 |  |  |  |  |  |  |  |
| <b>Flight Time</b> <i>(enter appropriate number of hours in each box)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                                  | Airplane Single Engine                                                                                                                                                                                                                                              | Airplane Multiengine                                                                                                                                                                                                          | Night                                                                                                                                                                                           | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |           | Rotorcraft                                                                    | Glider                                                                                                                                                                               | Lighter Than Air |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Simulated |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1931         | 169                                                                                                                                                                                                                                                                                                                                                | 1931                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                               | 191                                                                                                                                                                                             | 215                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 36        |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1801         | 169                                                                                                                                                                                                                                                                                                                                                | 1801                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                               | 191                                                                                                                                                                                             | 215                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 36        |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21           | 21                                                                                                                                                                                                                                                                                                                                                 | 21                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21           | 21                                                                                                                                                                                                                                                                                                                                                 | 21                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3            | 3                                                                                                                                                                                                                                                                                                                                                  | 3                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                               |                                                                                                                                                                                      |                  |                                                                           |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |      |  |     |     |    |  |  |  |                        |      |     |      |  |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |              |    |    |    |  |  |  |  |  |  |  |               |   |   |   |  |  |  |  |  |  |  |

| PILOT "B" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
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| <b>Pilot "B" Responsibilities at the Time of Accident</b><br><input type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot "B" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: _____<br/>           Middle Initial: _____<br/>           Last Name: _____         </div> <div>           City: _____<br/>           State: _____ ZIP: _____<br/>           Country: _____         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Age at time of Accident: _____ Date of Birth: _____ mm/dd/yyyy Certificate Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                                         | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single |                                                                                                                                                                                                                    |                                                                                                                                                                                      | <b>Seat Belt</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |                                                 | <b>Shoulder Harness</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None    <input type="checkbox"/> Student<br/> <input type="checkbox"/> Private    <input type="checkbox"/> Flight Instructor         </div> <div> <input type="checkbox"/> Recreational    <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Sport    <input type="checkbox"/> Airline Transport         </div> <div> <input type="checkbox"/> Flight Engineer    <input type="checkbox"/> Foreign<br/> <input type="checkbox"/> U.S. Military         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="checkbox"/> Pilot<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input type="checkbox"/> Class 3<br><input type="checkbox"/> Class 1 <input type="checkbox"/> Driver's License (Sport Pilot only)<br><input type="checkbox"/> Class 2 <input type="checkbox"/> Unknown                                                                      |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    | <b>Medical Certificate Validity</b><br><input type="checkbox"/> Without limitations/waivers<br><input type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           | <b>Date of Last Medical</b><br>_____ mm/dd/yyyy |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Waivers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____ mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                                                       |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | <b>Other Aircraft Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Free 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><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                      | <b>Instructor Rating(s)</b><br><i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Airplane Single-Engine<br/> <input type="checkbox"/> Airplane Multi-Engine<br/> <input type="checkbox"/> Gyroplane<br/> <input type="checkbox"/> Powered Lift           </div> <div> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport           </div> </div> |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      | <b>Student Endorsements</b> <i>(Include dates)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;">Flight Time <i>(enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="padding: 5px;">Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  | Flight Time <i>(enter appropriate number of hours in each box)</i> | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time <i>(enter appropriate number of hours in each box)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                       | Airplane Single Engine                                                                                                                                                                                                                                   | Airplane Multiengine                                                                                                                                                                                               | Night                                                                                                                                                                                | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           | Rotorcraft                                      | Glider                                                                                                                                                         | Lighter Than Air |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Simulated |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                    |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                                                 |                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

| <b>ADDITIONAL FLIGHT CREW MEMBERS (Exclusive of cabin attendants, complete the following information)</b>                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                           |  |  |                                                                                                                                                                                                                                                             |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |                                                                           |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |                                                                           |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<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>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |                                                                           |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |                                                                           |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<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>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |                                                                           |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |                                                                           |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<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>PASSENGER(S) / OTHER PERSONNEL (Include flight attendants; continue on separate sheet if necessary)</b>                                                                                                                                                                                                                                                                                                                                                               |  |  |                                                                           |  |  |                                                                                                                                                                                                                                                             |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                           |  |  | Seat                                                                                                                                                                                                                                                        | Crew                     | Non-Revenue              | Revenue                  | Non-Occupant             | FAA                      | Fatal                    | Serious Injury           | Minor Injury             | No Injury                | Unknown                  |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                           |  |  | _____                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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 time and point of departure, intended destination, and services obtained. Airplane was being returned to KBJC following completion of Annual Inspection and stopped at KGRI for intermediate refueling. The plane was positioned on the ramp facing the FBO for refueling. Upon starting engine, the plane began to develop forward movement despite pressure on both toe brakes. The brakes were pumped several times before they began to slow the plane. However forward motion prevented a complete stop prior to contacting the FBO building. The engine was stopped prior to making contact.

**RECOMMENDATION (How could this accident/incident have been prevented?)****Operator/Owner Safety Recommendation**

The plane could have been turned away from the building prior to leaving the ramp instead of focusing on pumping the brakes.

**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

03/03/2013  
*mm/dd/yyyy*

Signature

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

Type or Print Name: LARRY C MUNCH**Signature and Name of Person Filing Report if Other than Pilot/Operator**

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

Type or Print Name: \_\_\_\_\_

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

**FOR NTSB USE ONLY**

NTSB Accident/Incident No.

GEN13LA171

Reviewed by NTSB Regional Office

CHICAGO, IL

Name of Investigator

MG

Date Report Received

03/04/13