

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

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

## BASIC INFORMATION

### Accident/Incident Location

Nearest City/Place: PAYNESVILLE State: MN  
 ZIP: 56362 Country: STEARN  
 Latitude: 45° 22.3' Longitude: 94° 44.7'  
 (Enter in decimal degrees or degrees:minutes:seconds)

### Accident/Incident Date/Time

Date: 03 04 2017 Local Time: 13:30  
 mm/dd/yyyy Time Zone: CENTRAL

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

## AIRCRAFT INFORMATION

Registration Number: N 7524V

Manufacturer: MIKE JUD

Model: SANYTA SIDEWINDER

Serial Number: 212624

Year of Manufacture: 2012

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

- ☐ IFR-Equipped and Certified  
☐ Commercial Space Flight  
☐ Unmanned Aircraft

Maximum Gross Weight: 1800 lbs

Weight at Time of Accident/Incident: 1760 lbs

Number of Seats: 2 Flight Crew Seats: 2

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

Number of Engines: 1

### Category of Aircraft

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

### Type of Airworthiness Certificate

(Check all that apply)

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

### Landing Gear

(Check all that apply)

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

### Engine Type (Select one)

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

### Fuel System Type (Reciprocating)

- ☐ Carburetor ☒ Fuel-Injected

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg. mm/dd/yyyy | Rated Power<br><input type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time (hours) | Time Since: Inspection (hours) | Overhaul (hours) |
|--------|---------------------|---------------------|------------------------------|-------------------------|-------------------------------------------------------------------------------------------|--------------------|--------------------------------|------------------|
| Eng. 1 | <u>GM-AUTO</u>      | <u>346 cc LSI</u>   |                              | <u>1999</u>             | <u>180</u>                                                                                | <u>250</u>         | <u>30</u>                      |                  |
| Eng. 2 |                     |                     |                              |                         |                                                                                           |                    |                                |                  |
| Eng. 3 |                     |                     |                              |                         |                                                                                           |                    |                                |                  |
| Eng. 4 |                     |                     |                              |                         |                                                                                           |                    |                                |                  |

### Last Inspection Type

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

Date Last Inspection: \_\_\_\_\_  
 mm/dd/yyyy

Airframe Total Time: 250 hrs

hours measured at (Select one)

- ☐ Last Inspection ☒ Time of Accident/Incident

### Type of Maintenance Program (Select one)

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

### Description of Fire Extinguishing System

- ☐ None ☒ Specify: HAND HELD  
FIRE EXTINGUISHER

### Propeller 1

- ☐ Fixed Pitch  
☐ Controllable Pitch  
☒ Ground Adjustable

Manufacturer: JVO

Model: 3 BLADE MAGNUM

### Propeller 2

- ☐ Fixed Pitch  
☐ Controllable Pitch  
☐ Ground Adjustable

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

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

ELT Installed: ☐ Yes ☒ No

If Yes:

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

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

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

Was ELT still mounted in aircraft? ☐ Yes ☐ No

Was ELT still connected to antenna? ☐ Yes ☐ No

Did ELT Activate? ☐ Yes ☐ No

If activated:

Did ELT Aid in Locating Aircraft? ☐ Yes ☐ No

If not activated:

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

### Additional Equipment (Check all that apply)

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

# OWNER/OPERATOR INFORMATION

## Registered Aircraft Owner

Name: Michael Jude

City: ST CLOUD

State: MN ZIP: 56301

Fractional Ownership Aircraft: ☐ Yes ☒ No

Country: STEARN S

## Operator of Aircraft

☒ Same As Registered Owner

☒ Same Address as Registered Owner

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

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

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

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

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

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

## Operating Certificates Held

(Check all that apply)

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

## Regulation Flight Conducted Under

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

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

(Select one for each group)

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

## Purpose of Flight for FAR 91, 103, 133, 137

(Select one)

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

## Revenue Sightseeing Flight

☐ Yes ☒ No

## Air Medical Flight

☐ Yes ☒ No

# AIRPORT INFORMATION (Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)

Airport Name: PAYNESVILLE

Distance From Airport Center: 0.5 sm

Airport Identifier: Pex

Direction From Airport: 190 degrees true

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

Airport Elevation: 1183 ft. msl

## Runway Information

Runway ID: 29 (L/R/C) Length: 3300 ft Width: 75 ft

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

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

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

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

## Approach/Departure Segment (Select one)

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

## IFR Approach (Check all that apply)

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

## VFR Approach (Check all that apply)

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

| "FLIGHT CREWMEMBER 1" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
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| <b>"Flight Crewmember 1" Responsibilities at the Time of Accident/Incident</b><br><input checked="" type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 1" was pilot flying</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 1" Identification</b><br>First Name: <u>MICHAEL</u> City of Residence: <u>ST. CLOUD</u><br>Middle Initial: <u>C</u> State: <u>MN</u> ZIP: <u>56301</u><br>Last Name: <u>JUDE</u> Country: <u>STEARN S</u><br>Age at time of Accident/Incident: <u>71</u> Date of Birth: <span style="background-color: black; color: black;">[REDACTED]</span> mm/dd/yyyy<br>Certificate Number: <span style="background-color: black; color: black;">[REDACTED]</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input checked="" type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | <b>Seat Occupied</b><br><input checked="" type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single                                                                                      |                                                                              | <b>Restraint Type</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input checked="" type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input checked="" type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Inflatable Restraints</b><br><input checked="" type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input checked="" type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input checked="" type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input checked="" type="radio"/> Unknown                                                                         |                                                                              | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input checked="" type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                           |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Date of Last Medical</b><br><u>unknown</u><br>mm/dd/yyyy                                                                                                                                                                               |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b><br><u>CORRECTED VISION</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Special Issuance</b><br><u>EXPIRED</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>03 04 2013</u><br>mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                     | <b>Flight Review Aircraft</b><br>Make: <u>PIPER</u><br>Model: <u>WARRIOR</u> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b> (Check all that apply)<br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              | <b>Other Aircraft Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                              | <b>Instrument Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift                                                                                                                                                                                                                                                                                                                                                                                                               |       | <b>Instructor Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine <input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Airplane Multi-Engine <input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Gyroplane <input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift <input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       | <b>Student Endorsements</b> (Include dates)                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">Flight Time (Enter appropriate number of hours in each box)</th> <th rowspan="2">All Aircraft</th> <th rowspan="2">This Make &amp; Model</th> <th rowspan="2">Airplane Single Engine</th> <th rowspan="2">Airplane Multiengine</th> <th rowspan="2">Night</th> <th colspan="2">Instrument</th> <th rowspan="2">Rotorcraft</th> <th rowspan="2">Glider</th> <th rowspan="2">Lighter Than Air</th> </tr> <tr> <th>Actual</th> <th>Simulated</th> </tr> </thead> <tbody> <tr> <td>Total Time</td> <td>466</td> <td>256</td> <td>400</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pilot in Command (PIC)</td> <td>380</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>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>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>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>Last 30 Days</td> <td>5</td> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Last 24 Hours</td> <td>0.5</td> <td>0.5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  | Flight Time (Enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time | 466 | 256 | 400 |  |  |  |  |  |  |  | Pilot in Command (PIC) | 380 |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days | 5 | 5 |  |  |  |  |  |  |  |  | Last 24 Hours | 0.5 | 0.5 |  |  |  |  |  |  |  |  |
| Flight Time (Enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                   | Airplane Single Engine                                                       | Airplane Multiengine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Night | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                           | Rotorcraft | Glider | Lighter Than Air |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Simulated                                                                                                                                                                                                                                 |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 466          | 256                                                                                                                                                                                                                                                                                                                                 | 400                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 380          |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5            | 5                                                                                                                                                                                                                                                                                                                                   |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0.5          | 0.5                                                                                                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                           |            |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |     |     |  |  |  |  |  |  |  |                        |     |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |   |   |  |  |  |  |  |  |  |  |               |     |     |  |  |  |  |  |  |  |  |

N/A

| "FLIGHT CREWMEMBER 2" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
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| <b>"Flight Crewmember 2" Responsibilities at the Time of Accident/Incident</b><br><input type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 2" was pilot flying</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 2" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: _____<br/>           Middle Initial: _____<br/>           Last Name: _____         </div> <div>           City of Residence: _____<br/>           State: _____ ZIP: _____<br/>           Country: _____         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Age at time of Accident/Incident: _____</div> <div>Date of Birth: _____ mm/dd/yyyy</div> </div> <div style="text-align: center; margin-top: 5px;">Certificate Number: _____</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                   | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single                                                                                             |                                                              |       | <b>Restraint Type</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div style="flex: 1;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> None</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Flight Instructor</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Commercial</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> US Military</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Private</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Recreational</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Airline Transport</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Foreign</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Student</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Sport</div> <div style="flex: 1; min-width: 150px;"><input type="checkbox"/> Flight Engineer</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                  |           | <b>Date of Last Medical</b><br><div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> <div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b><br><div style="height: 40px; border: 1px solid black;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Special Issuance</b><br><div style="height: 40px; border: 1px solid black;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____<br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                   |                                                                                                                                                                                                                                                                                                                                 | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____ |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b> <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> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                              |       | <b>Instrument Rating(s)</b> <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> <i>(Check all that apply)</i><br><div style="display: flex;"> <div style="flex: 1;"> <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 style="flex: 1;"> <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><br><div style="height: 60px; border: 1px solid black;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                   |                                                                                                                                                                                                                                                                                                                                 |                                                              |       | <b>Student Endorsements</b> <i>(Include dates)</i><br><div style="height: 60px; border: 1px solid black;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th rowspan="2" style="width: 20%;">Flight Time <i>(Enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="width: 5%;">All Aircraft</th> <th rowspan="2" style="width: 5%;">This Make &amp; Model</th> <th rowspan="2" style="width: 5%;">Airplane Single Engine</th> <th rowspan="2" style="width: 5%;">Airplane Multiengine</th> <th rowspan="2" style="width: 5%;">Night</th> <th colspan="2" style="width: 10%;">Instrument</th> <th rowspan="2" style="width: 5%;">Rotorcraft</th> <th rowspan="2" style="width: 5%;">Glider</th> <th rowspan="2" style="width: 5%;">Lighter Than Air</th> </tr> <tr> <th>Actual</th> <th>Simulated</th> </tr> </thead> <tbody> <tr> <td>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>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>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>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>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>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>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 CREWMEMBERS</b> (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Crew Name and Address</b> <i>NONE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                                                                         | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                                                |                                                                                                                                                                                   |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                                                         | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Pilot Certificate(s)</b> (Check all that apply) <div style="display: flex; justify-content: space-between; font-size: small;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student             </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport             </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer             </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign             </div> </div> |  |  |  |                                                                                                                                         | <b>Restraint Type:</b><br><div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                         | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |                                                                                                                                         | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                                                |                                                                                                                                                                                   |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                                                         | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Pilot Certificate(s)</b> (Check all that apply) <div style="display: flex; justify-content: space-between; font-size: small;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student             </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport             </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer             </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign             </div> </div> |  |  |  |                                                                                                                                         | <b>Restraint Type:</b><br><div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                         | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>PASSENGER(S) / OTHER PERSONNEL</b> (Include cabin crew; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                |                                                                                                                                                                                                |                                                                                                                                                                                   |
| <b>Name and Address</b> <i>NONE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | <b>Seat</b>                                                                                                                             | <b>Injury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Restraint Type</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                | <b>Inflatable Restraints</b>                                                                                                                                                                   | <b>Age</b>                                                                                                                                                                        |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; font-size: small;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other             </div>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: ____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; font-size: small;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other             </div>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: ____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; font-size: small;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other             </div>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: ____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; font-size: small;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other             </div>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: ____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <div style="display: flex; font-size: small;"> <div style="margin-right: 10px;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |

|                             |                            |                          |                                                                                                    |
|-----------------------------|----------------------------|--------------------------|----------------------------------------------------------------------------------------------------|
| <b>Last Departure Point</b> | <b>Time of Departure</b>   | <b>Destination</b>       | <b>Type Flight Plan Filed</b>                                                                      |
| Airport ID: <u>8V6</u>      | Time: <u>13.30</u>         | Airport ID: <u>PEX</u>   | <input checked="" type="radio"/> None <input type="radio"/> VFR/IFR                                |
| City: <u>CLARE LAKE</u>     | Time Zone: <u>CAN TIME</u> | City: <u>PAYNESVILLE</u> | <input type="radio"/> Company VFR <input type="radio"/> IFR                                        |
| State: <u>MN</u>            |                            | State: <u>MN</u>         | <input type="radio"/> Military VFR <input type="radio"/> Unknown                                   |
| Country: <u>SHERBORN</u>    | <u>CENTRAL</u>             | Country: <u>STEARNS</u>  | <input type="radio"/> VFR                                                                          |
|                             |                            |                          | <b>Activated?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

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

|                                          |                                      |                                      |                                               |                                       |
|------------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------------------|---------------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Special VFR | <input type="checkbox"/> Special IFR | <input type="checkbox"/> VFR Flight Following | <input type="checkbox"/> Cruise       |
| <input type="checkbox"/> VFR             | <input type="checkbox"/> IFR         | <input type="checkbox"/> VFR On Top  | <input type="checkbox"/> Traffic Advisory     | <input type="checkbox"/> Unknown / NA |

|                                                                             |                                             |                                                         |                                                   |                                          |
|-----------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------------|---------------------------------------------------|------------------------------------------|
| <b>Airspace where the accident/incident occurred</b> (Check all that apply) |                                             |                                                         |                                                   | <b>Altitude of In-Flight Occurrence:</b> |
| <input type="checkbox"/> Class A                                            | <input checked="" type="checkbox"/> Class G | <input type="checkbox"/> Military Operations Area (MOA) | <input type="checkbox"/> Special                  | _____ ft msl                             |
| <input type="checkbox"/> Class B                                            | <input type="checkbox"/> Demo Area          | <input type="checkbox"/> Airport Advisory Area          | <input type="checkbox"/> Air Traffic Control Area |                                          |
| <input type="checkbox"/> Class C                                            | <input type="checkbox"/> Warning Area       | <input type="checkbox"/> Jet Training Area              | <input type="checkbox"/> Unknown                  |                                          |
| <input type="checkbox"/> Class D                                            | <input type="checkbox"/> Prohibited Area    | <input type="checkbox"/> TRSA                           |                                                   |                                          |
| <input type="checkbox"/> Class E                                            | <input type="checkbox"/> Restricted Area    | <input type="checkbox"/> FAR 93                         |                                                   |                                          |
|                                                                             |                                             |                                                         |                                                   |                                          |

| Source of Pilot Weather Information<br>(Check all that apply) |                                   | Weather Observation Facility                     |  |
|---------------------------------------------------------------|-----------------------------------|--------------------------------------------------|--|
| <input type="checkbox"/> National Weather Service             | <input type="checkbox"/> Company  | Facility ID: _____                               |  |
| <input type="checkbox"/> Flight Service Station               | <input type="checkbox"/> Military | Observation Time: _____                          |  |
| <input checked="" type="checkbox"/> TV/Radio                  | <input type="checkbox"/> Internet | Time Zone: _____                                 |  |
| <input type="checkbox"/> Automated Report                     | <input type="checkbox"/> None     | Distance from Accident Site: _____ nm            |  |
| <input type="checkbox"/> Commercial Weather Service (DUATS)   | <input type="checkbox"/> Unknown  | Direction from Accident Site: _____ degrees true |  |
| <input type="checkbox"/> On-Board Weather                     |                                   |                                                  |  |

|                                                                                                                               |                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night |
|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

[illegible]

|                                                                                                                    |                                                                                                                                       |                                                                                               |                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Wind Direction</b><br><input checked="" type="checkbox"/> Variable<br><br>-or-<br>Direction: _____ degrees true | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br><br>-or-<br>Speed: <u>10</u> kts | <b>Wind Gusts</b><br><input type="checkbox"/> Not Gusting<br><br>-or-<br>Speed: <u>20</u> kts | <b>Visibility</b> <u>10</u> miles<br>RVR: _____ feet<br>RVV: _____ miles<br><br><b>Density Altitude:</b> _____ ft |
|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|

| Intensity of Precipitation                                                                                                                                 | Type of Precipitation <i>(Check all that apply)</i>                                                                                                                                  |                                                                                                                                                                                                    |                                                                                                                                                                            |                                                                                                                                                                                                                                                | Restriction to Visibility <i>(Check all that apply)</i>                                                                                                                                                        |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| <input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Heavy<br><input type="radio"/> N/A<br><input type="radio"/> Unknown | <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 | <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 | <input type="checkbox"/> Freezing Rain<br><input type="checkbox"/> Snow Shower<br><input type="checkbox"/> Ice Pellets Shower<br><input type="checkbox"/> Freezing Drizzle | <input checked="" type="checkbox"/> None<br><input type="checkbox"/> Blowing Dust<br><input type="checkbox"/> Blowing Sand<br><input type="checkbox"/> Blowing Snow<br><input type="checkbox"/> Blowing Spray<br><input type="checkbox"/> Dust | <input type="checkbox"/> Fog<br><input type="checkbox"/> Ground Fog<br><input type="checkbox"/> Haze<br><input type="checkbox"/> Ice Fog<br><input type="checkbox"/> Smoke<br><input type="checkbox"/> Unknown |  |  |  |

| Icing Forecast                        |                               | Icing Actual                          |                               | Turbulence                                     |                                   |
|---------------------------------------|-------------------------------|---------------------------------------|-------------------------------|------------------------------------------------|-----------------------------------|
| Amount                                | Type                          | Amount                                | Type                          | Type (Check all that apply)                    | Severity                          |
| <input checked="" type="radio"/> None | <input type="radio"/> N/A     | <input checked="" type="radio"/> None | <input type="radio"/> N/A     | <input checked="" type="checkbox"/> None       | <input type="checkbox"/> Light    |
| <input type="radio"/> Trace           | <input type="radio"/> Rime    | <input type="radio"/> Trace           | <input type="radio"/> Rime    | <input type="checkbox"/> Clear Air             | <input type="checkbox"/> Moderate |
| <input type="radio"/> Light           | <input type="radio"/> Clear   | <input type="radio"/> Light           | <input type="radio"/> Clear   | <input type="checkbox"/> Terrain-Induced       | <input type="checkbox"/> Severe   |
| <input type="radio"/> Moderate        | <input type="radio"/> Mixed   | <input type="radio"/> Moderate        | <input type="radio"/> Mixed   | <input type="checkbox"/> Convective Turbulence | <input type="checkbox"/> Extreme  |
| <input type="radio"/> Severe          | <input type="radio"/> Unknown | <input type="radio"/> Severe          | <input type="radio"/> Unknown |                                                |                                   |
| <input type="radio"/> Unknown         |                               | <input type="radio"/> Unknown         |                               |                                                |                                   |

# DAMAGE TO AIRCRAFT AND OTHER PROPERTY

## Aircraft Damage

- ☐ None  
☐ Minor  
☒ Substantial  
☒ Destroyed  
☐ Unknown

## Aircraft Fire

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

## Aircraft Explosion

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

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

AS I LANDED IN A VERY SOFT field, the WINGS CONTACTED THE ground AND Bent, the LANDING gear dug in AND Bent, AND the fuselage TWISTED AND Bent. THE AIRCRAFT IS NOT WORTH REPAIRING AND I WILL SCRAP IT

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

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

03-04-2017 13:00 hrs APT 8Y6  
 PREFLIGHT: 13 GAL fuel (1.7 hr) LTANK, 15 GAL fuel 2.0 hr RTANK, engine oil OK, ENGINE COOLANT level OK, PROP OK, TIRES OK, NO VISIBLE GIGS detected. I STARTED THE ENGINE AND AFTER A 5 MIN WARM UP I TAXIED TO RW 18. AFTER A SCAN OF THE INSTRUMENTS AND GAUGES I RADIOED MY INTENTION ON 122.9. THERE WAS NO OTHER A/C IN THE AREA SO I DEPARTED. AS I CLIMBED TO 3500 MSL I TURNED TO 265° TOWARD PEX. 10 MILES FROM PEX I REDUCED POWER AND BEGAN TO DESCEND. 4 MILES FROM PEX I CALLED OUT MY POSITION AND MY INTENTIONS. THERE ~~WERE~~<sup>WERE</sup> NO OTHER AIRCRAFT VISIBLE IN THE AREA. I LANDED ON RWY 29 AND THEN APPLIED POWER FOR A TOUCH AND GO. AS I CLIMBED, I SMELLED ENGINE COOLANT. AS I TURNED CROSSWIND I AGAIN SMELLED COOLANT. AS I ENTERED DOWNWIND (29) I LOST POWER CONT P 11

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

Operator/Owner Safety Recommendation

AT THIS TIME I DON'T HAVE  
ACCESS TO THE AIRCRAFT

**MECHANICAL MALFUNCTION/FAILURE** (If more space is needed, continue on separate sheet)Was there Mechanical Malfunction/Failure? ☒ Yes ☐ No

(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)

CMC AUTO ENGINE LOST COOLANT IN  
FLIGHT, BEGAN TO OVERHEAT, AND THE  
ECU SHUT DOWN THE ENGINE TO AVOID  
ENGINE DAMAGE

Total Time/Cycles  
On Part

250 Hours

Cycles

Time Since This Part  
Inspected/Overhauled

30 Hours

**FUEL & SERVICES INFORMATION**

Fuel on Board at Last Takeoff

(Convert from pounds, as necessary)

 $\frac{R}{15} + \frac{L}{13} = 28$  Gallons

Fuel Type

☐ 80/87☐ 115/145☐ Jet B☒ Other, specify☐ 100 Low Lead☐ Jet A☐ JP8☐ 100/130☐ Jet A-1☒ Automotive89 OCTANE  
AUTO GAS

Other Services, if Any, Prior to Departure

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

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

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

Aircraft Registration Number

Manufacturer:

Model:

Damage to Other Aircraft

☐ Destroyed☐ Minor☐ Substantial☐ None

Registered Owner of Other Aircraft

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

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

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

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

Pilot of Other Aircraft

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

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

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

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

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

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

CONT. Farm P 9

I didn't think I would make BACK TO The Runway. The Roads in The AREA had vehicle TRAFFIC. I landed in A NEARBY farm field. The field was very soft AND The landing roll was ABOUT 70 feet I was using my 4 POINT HARNESS, BUT I WAS NOT PREPARED for RAPID deceleration. AS A RESULT I fractured my RIGHT wrist AND Received other minor injuries 7524 V WAS damaged BEYOND REPAIR. There was NO OTHER damage on The ground HOWEVER A Tow TRUCK BECAME STUCK AND had To Be Towed OUT CAUSING some Ruts in The field

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

Date of this Report

03/17/2017  
mm/dd/yyyy

Name of Pilot/Operator:

MICHAEL C JUDÉ

Signature: 

- or -

☐ Check here to electronically sign this document

If a Person Other than Pilot/Operator is Filing Report

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

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

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

- or -

☐ Check here to electronically sign this document**FOR NTSB USE ONLY**NTSB Accident/Incident No.  
CEN17LA117Reviewed by NTSB Regional Office  
Central RegionName of Investigator  
Pamela S SullivanDate Report Received  
3-23-2017