

# 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

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| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>KEIK Erie</u> State: <u>CO</u><br>ZIP: <u>80516</u> Country: <u>USA</u><br>Latitude: <u>40.0078</u> Longitude: <u>-105.05</u><br><i>(Enter in decimal degrees or degrees:minutes:seconds)</i> | <b>Accident/Incident Date/Time</b><br>Date: <u>02/26/2023</u> Local Time: <u>9:15 AM</u><br><i>mm/dd/yyyy</i><br>Time Zone: <u>Mountain</u><br><b>Collision with Other Aircraft:</b> <input type="radio"/> Midair <input type="radio"/> On-ground <input checked="" type="radio"/> None |
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## AIRCRAFT INFORMATION

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| <b>Registration Number:</b> <u>N840T</u><br><b>Manufacturer:</b> <u>Cub Crafters</u><br><b>Model:</b> <u>FX3</u><br><b>Serial Number:</b> <u>CCX2000-0150</u><br><b>Year of Manufacture:</b> <u>2022</u><br><b>Amateur-Built:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No <i>If Yes:</i> <input checked="" type="radio"/> Kit/Plans <input type="radio"/> Original Design Make: <u>CC FX3</u> | <input checked="" type="checkbox"/> IFR-Equipped and Certified<br><input type="checkbox"/> Commercial Space Flight<br><input type="checkbox"/> Unmanned Aircraft<br><b>Maximum Gross Weight:</b> <u>2000</u> lbs<br><b>Weight at Time of Accident/Incident:</b> <u>1500</u> lbs<br><b>Number of Seats:</b> <u>2</u> Flight Crew Seats: <u>1</u><br>Cabin Crew Seats: _____ Passenger Seats: <u>1</u><br><b>Number of Engines:</b> <u>1</u> |
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| <b>Category of Aircraft</b><br><input checked="" type="radio"/> Airplane<br><input type="radio"/> Balloon<br><input type="radio"/> Blimp/Dirigible<br><input type="radio"/> Glider<br><input type="radio"/> Gyroplane<br><input type="radio"/> Helicopter<br><input type="radio"/> Powered Lift<br><input type="radio"/> Rocket<br><input type="radio"/> Ultralight<br><input type="radio"/> Unknown | <b>Type of Airworthiness Certificate</b><br><i>(Check all that apply)</i><br><table style="width: 100%;"> <tr> <th style="text-align: left;">Standard</th> <th style="text-align: left;">Special</th> </tr> <tr> <td><input checked="" type="checkbox"/> Normal</td> <td><input type="checkbox"/> Restricted</td> </tr> <tr> <td><input type="checkbox"/> Aerobatic</td> <td><input type="checkbox"/> Limited</td> </tr> <tr> <td><input type="checkbox"/> Balloon</td> <td><input type="checkbox"/> Provisional</td> </tr> <tr> <td><input type="checkbox"/> Commuter</td> <td><input type="checkbox"/> Special Flight</td> </tr> <tr> <td><input type="checkbox"/> Transport</td> <td><input checked="" type="checkbox"/> Experimental</td> </tr> <tr> <td><input type="checkbox"/> Utility</td> <td><input type="checkbox"/> Special Light-Sport</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Experimental Light-Sport</td> </tr> </table> <input type="checkbox"/> Certificate of Authorization or Waiver (COA)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> Unknown | Standard | Special | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Restricted | <input type="checkbox"/> Aerobatic | <input type="checkbox"/> Limited | <input type="checkbox"/> Balloon | <input type="checkbox"/> Provisional | <input type="checkbox"/> Commuter | <input type="checkbox"/> Special Flight | <input type="checkbox"/> Transport | <input checked="" type="checkbox"/> Experimental | <input type="checkbox"/> Utility | <input type="checkbox"/> Special Light-Sport |  | <input type="checkbox"/> Experimental Light-Sport | <b>Landing Gear</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> Retractable<br><input type="checkbox"/> Tricycle <input checked="" type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Other Launch/Recovery System<br><input type="checkbox"/> None <input type="checkbox"/> Unknown | <b>Engine Type (Select one)</b><br><input checked="" type="radio"/> Reciprocating <input type="radio"/> Liquid Rocket<br><input type="radio"/> Turbo Shaft <input type="radio"/> Solid Rocket<br><input type="radio"/> Turbo Prop <input type="radio"/> Hybrid Rocket<br><input type="radio"/> Turbo Jet <input type="radio"/> None<br><input type="radio"/> Turbo Fan <input type="radio"/> Unknown<br><input type="radio"/> Electric<br><b>Fuel System Type (Reciprocating)</b><br><input type="radio"/> Carburetor <input checked="" type="radio"/> Fuel-Injected |
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| Standard                                                                                                                                                                                                                                                                                                                                                                                             | Special                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input checked="" type="checkbox"/> Normal                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Restricted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Aerobatic                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Limited                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Balloon                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Provisional                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Commuter                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Special Flight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Transport                                                                                                                                                                                                                                                                                                                                                                   | <input checked="" type="checkbox"/> Experimental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Utility                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Special Light-Sport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Experimental Light-Sport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |         |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                                  |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br><i>mm dd yyyy</i> | Rated Power<br><input checked="" type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time<br>(hours) | Time Since:<br>Inspection<br>(hours) | Overhaul<br>(hours) |
|--------|---------------------|---------------------|------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------|
| Eng. 1 | Lycoming            | CC363i              | CC363i-2201                  | 05/06/2022                        | 186                                                                                                  | 55.4                  | new                                  |                     |
| Eng. 2 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |
| Eng. 3 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |
| Eng. 4 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |

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| <b>Last Inspection Type</b><br><input type="radio"/> 100-Hour <input type="radio"/> Continuous Airworthiness<br><input type="radio"/> AAIP <input type="radio"/> Conditional Inspection<br><input type="radio"/> Annual <input type="radio"/> Unknown<br><b>Date Last Inspection:</b> <u>09/23/2022</u><br><i>mm/dd/yyyy</i><br><b>Airframe Total Time:</b> <u>55.4</u> hrs<br>hours measured at <i>(Select one)</i><br><input type="radio"/> Last Inspection <input checked="" type="radio"/> Time of Accident/Incident | <b>Propeller 1</b> <input type="radio"/> Fixed Pitch <input checked="" type="radio"/> Controllable Pitch <input type="radio"/> Ground Adjustable<br>Manufacturer: <u>Hartzell</u><br>Model: <u>HC-C2YR-1NW</u><br><b>Propeller 2</b> <input type="radio"/> Fixed Pitch <input checked="" type="radio"/> Controllable Pitch <input type="radio"/> Ground Adjustable<br>Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>ELT Installed:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br><i>If Yes:</i><br><b>ELT Manufacturer:</b> <u>Kannad</u><br><b>Model or Part No.:</b> <u>7511</u><br><b>TSO No.:</b> <input type="radio"/> C91 (121.5 MHz) <input type="radio"/> C91a (121.5 MHz) <input checked="" type="radio"/> C126 (406 MHz)<br><b>Was ELT still mounted in aircraft?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br><b>Was ELT still connected to antenna?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br><b>Did ELT Activate?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No<br><i>If activated:</i><br><b>Did ELT Aid in Locating Aircraft?</b> <input type="radio"/> Yes <input checked="" type="radio"/> No<br><i>If not activated:</i><br><b>Indicate Reason:</b> <input type="checkbox"/> Impact Damage <input type="checkbox"/> Fire Damage <input type="checkbox"/> Battery Expired/Damaged <input checked="" type="checkbox"/> Unknown |
| <b>Type of Maintenance Program (Select one)</b><br><input checked="" type="radio"/> Annual<br><input type="radio"/> Conditional (Amateur-built only)<br><input type="radio"/> Manufacturer's Inspection Program<br><input type="radio"/> Other Approved Inspection Program (AAIP)<br><input type="radio"/> Continuous Airworthiness<br><input type="radio"/> Other, specify: _____                                                                                                                                       | <b>Additional Equipment (Check all that apply)</b><br><input checked="" type="checkbox"/> ADS-B<br><input type="checkbox"/> Airframe Parachute<br><input type="checkbox"/> Angle of Attack Indicator<br><input checked="" type="checkbox"/> Autopilot<br><input type="checkbox"/> Data Recorder<br><input type="checkbox"/> Electronic Flight Bag or Handheld Device<br><input type="checkbox"/> Electronic Multifunction Display<br><input checked="" type="checkbox"/> Electronic Primary Flight Display<br><input type="checkbox"/> Handheld GPS<br><input type="checkbox"/> Heads Up Display<br><input checked="" type="checkbox"/> Onboard Weather<br><input type="checkbox"/> Satellite Tracking Device<br><input checked="" type="checkbox"/> Stall Warning System<br><input type="checkbox"/> Video Recording Device<br><input type="checkbox"/> Other, Specify: _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Description of Fire Extinguishing System</b><br><input type="radio"/> None<br><input type="radio"/> Specify: Not Used                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| OWNER/OPERATOR INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
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| <b>Registered Aircraft Owner</b><br>Name: <u>Mesa Aviation LLC</u><br>Fractional Ownership Aircraft: <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | City: <u>Brookings</u><br>State: <u>SD</u> ZIP: <u>57006</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <b>Operator of Aircraft</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>Name: _____<br>Doing Business As: _____<br>Air Carrier/Operator Designator (4 Character Code): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/> Same Address as Registered Owner<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| <b>Operating Certificates Held</b><br><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (FAR 121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (FAR 129)<br><input type="checkbox"/> Rotorcraft External Load (FAR 133)<br><input type="checkbox"/> Commuter Air Carrier (FAR 135)<br><input type="checkbox"/> On-Demand Air Taxi (FAR 135)<br><input type="checkbox"/> Commercial Air Tour (FAR 136)<br><input type="checkbox"/> Agricultural Aircraft (FAR 137)<br><input type="checkbox"/> Pilot School (FAR 141)<br><input type="checkbox"/> Certificate of Authorization or Waiver (COA)<br><input type="checkbox"/> Commercial Space Transportation<br>Experimental Permit<br><input type="checkbox"/> Commercial Space Transportation License<br><input type="checkbox"/> Other Operator of Large Aircraft                                                                                                            | <b>Regulation Flight Conducted Under</b><br><input checked="" type="radio"/> FAR 91 <input type="radio"/> FAR 129 <input type="radio"/> FAR 415<br><input type="radio"/> FAR 103 <input type="radio"/> FAR 133 <input type="radio"/> FAR 431<br><input type="radio"/> FAR 121 <input type="radio"/> FAR 135 <input type="radio"/> FAR 435<br><input type="radio"/> FAR 125 <input type="radio"/> FAR 137 <input type="radio"/> FAR 437<br><br><input type="radio"/> FAR 91 Special Flight<br><input type="radio"/> Non-US, Commercial<br><input type="radio"/> Non-US, Non-commercial<br><br><input type="radio"/> Public Aircraft <i>(Select one)</i><br><input type="radio"/> Armed Forces<br><input type="radio"/> Federal<br><input type="radio"/> State<br><input type="radio"/> Local<br><input type="radio"/> Unknown | <b>Revenue Operation for FAR 121, 125, 129, 135</b><br><i>(Select one for each group)</i><br><br><div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Scheduled or Commuter<br/> <input type="radio"/> Non-Scheduled or Air Taxi               </div> <div> <input type="radio"/> Domestic<br/> <input type="radio"/> International               </div> </div><br><input type="radio"/> Passenger<br><input type="radio"/> Cargo<br><input type="radio"/> Mail Contract Only                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>Revenue Sightseeing Flight</b><br><input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Air Medical Flight</b><br><input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>AIRPORT INFORMATION</b> <i>(Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| Airport Name: <u>Erie Municipal Airport</u><br>Airport Identifier: <u>KEIK</u><br>Proximity to Airport: <input type="radio"/> Off Airport/Airstrip <input checked="" type="radio"/> On Airport/Airstrip <input type="radio"/> N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Distance From Airport Center: <u>25</u> sm<br>Direction From Airport: _____ degrees true<br>Airport Elevation: <u>5119</u> ft. msl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>Runway Information</b><br>Runway ID: <u>34</u> (L/R/C) Length: <u>4700</u> ft Width: <u>60</u> ft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Condition of Runway/Landing Surface</b> <i>(Check all that apply)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>Runway/Landing Surface</b> <i>(Check all that apply)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Asphalt    <input type="checkbox"/> Grass/Turf    <input type="checkbox"/> Macadam    <input type="checkbox"/> Water<br/> <input checked="" type="checkbox"/> Concrete    <input type="checkbox"/> Gravel    <input type="checkbox"/> Metal/Wood<br/> <input type="checkbox"/> Dirt    <input type="checkbox"/> Ice    <input type="checkbox"/> Snow    <input type="checkbox"/> Unknown               </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input checked="" type="checkbox"/> Dry<br/> <input type="checkbox"/> Holes<br/> <input type="checkbox"/> Ice Covered<br/> <input type="checkbox"/> Rough<br/> <input type="checkbox"/> Rubber Deposits<br/> <input type="checkbox"/> Slush-Covered               </div> <div style="width: 33%;"> <input type="checkbox"/> Snow-Compacted<br/> <input type="checkbox"/> Snow-Crusted<br/> <input type="checkbox"/> Snow-Dry<br/> <input type="checkbox"/> Snow-Wet<br/> <input type="checkbox"/> Soft<br/> <input type="checkbox"/> Vegetation               </div> <div style="width: 33%;"> <input type="checkbox"/> Water-Calm<br/> <input type="checkbox"/> Water-Choppy<br/> <input type="checkbox"/> Water-Glassy<br/> <input type="checkbox"/> Wet<br/> <input type="checkbox"/> Unknown               </div> </div> |  |
| <b>Approach/Departure Segment</b> <i>(Select one)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="radio"/> Taxi<br/> <input type="radio"/> Takeoff<br/> <input type="radio"/> Initial Climb               </div> <div style="width: 25%;"> <input type="radio"/> VFR Departure<br/> <input type="radio"/> IFR Departure Procedure/Clearance               </div> <div style="width: 25%;"> <input type="radio"/> On Instrument Approach<br/> <input checked="" type="radio"/> Landing               </div> <div style="width: 25%;"> <input type="radio"/> Downwind<br/> <input type="radio"/> Base<br/> <input type="radio"/> Final<br/> <input type="radio"/> Crosswind               </div> <div style="width: 25%;"> <input type="radio"/> Low Approach<br/> <input type="radio"/> Go Around<br/> <input type="radio"/> Aborted Landing (after touchdown)<br/> <input type="radio"/> Unknown               </div> </div>                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| <b>IFR Approach</b> <i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> ADF/NDB<br/> <input type="checkbox"/> SDF<br/> <input type="checkbox"/> VOR/TVOR<br/> <input type="checkbox"/> VOR/DME<br/> <input type="checkbox"/> TACAN               </div> <div style="width: 25%;"> <input type="checkbox"/> PAR<br/> <input type="checkbox"/> Sidestep<br/> <input type="checkbox"/> ILS<br/> <input type="checkbox"/> Localizer Only<br/> <input type="checkbox"/> LOC-back course<br/> <input type="checkbox"/> RNAV               </div> <div style="width: 25%;"> <input type="checkbox"/> MLS<br/> <input type="checkbox"/> LDA<br/> <input type="checkbox"/> ASR<br/> <input type="checkbox"/> Visual<br/> <input type="checkbox"/> Contact<br/> <input type="checkbox"/> Circling               </div> <div style="width: 25%;"> <input type="checkbox"/> Practice<br/> <input type="checkbox"/> GPS<br/> <input type="checkbox"/> Unknown               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>VFR Approach</b> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input checked="" type="checkbox"/> Traffic Pattern<br/> <input type="checkbox"/> Straight-In<br/> <input type="checkbox"/> Valley/Terrain Following<br/> <input type="checkbox"/> Go Around<br/> <input checked="" type="checkbox"/> Full Stop               </div> <div style="width: 50%;"> <input type="checkbox"/> Stop and Go<br/> <input type="checkbox"/> Touch and Go<br/> <input type="checkbox"/> Simulated Forced Landing<br/> <input type="checkbox"/> Forced Landing<br/> <input type="checkbox"/> Precautionary Landing<br/> <input type="checkbox"/> Unknown               </div> </div>                                                                                                                               |  |

| "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 type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>"Flight Crewmember 1" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: <u>Edward</u><br/>           Middle Initial: <u>H</u><br/>           Last Name: <u>Eggers</u> </div> <div>           City of Residence: <u>Brookings</u><br/>           State: <u>SD</u>    ZIP: <u>57006</u><br/>           Country: <u>USA</u> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Age at time of Accident/Incident: <u>68</u></div> <div>Date of Birth: <span style="background-color: black; color: black;">[REDACTED]</span> <small>mm/dd/yyyy</small></div> </div> <div style="text-align: center; margin-top: 5px;">Certificate Number: <span style="background-color: black; color: black;">[REDACTED]</span></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Degree of Injury</b><br><input checked="" 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 checked="" type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single                                                                                             |                        | <b>Restraint Type</b><br><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 checked="" 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 checked="" 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 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> <i>(Check all that apply)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 50%;"><input type="checkbox"/> Commercial</div> <div style="width: 50%;"><input type="checkbox"/> US Military</div> <div style="width: 50%;"><input checked="" type="checkbox"/> Private</div> <div style="width: 50%;"><input type="checkbox"/> Recreational</div> <div style="width: 50%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 50%;"><input type="checkbox"/> Foreign</div> <div style="width: 50%;"><input type="checkbox"/> Student</div> <div style="width: 50%;"><input type="checkbox"/> Sport</div> <div style="width: 50%;"><input type="checkbox"/> Flight Engineer</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Medical Certificate Validity</b><br><input checked="" type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>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 checked="" type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                                |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Date of Last Medical</b><br><u>02/18/2023</u><br><small>mm/dd/yyyy</small>                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Medical Certificate Limitations</b><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Medical Certificate Special Issuance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>10/19/2021</u><br><small>mm/dd/yyyy</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Flight Review Aircraft</b><br>Make: <u>Cessna</u><br>Model: <u>T206HD</u>                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Airplane Rating(s)</b> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | <b>Other Aircraft Rating(s)</b> <i>(Check all that apply)</i><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> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                         | <b>Instructor Rating(s)</b> <i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><div style="display: flex; justify-content: flex-end; margin-top: 5px;"> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport             </div> |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         | <b>Student Endorsements</b> <i>(Include dates)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;">Flight Time <i>(Enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 5px;">Total Time</td> <td>824</td> <td>19</td> <td>824</td> <td>0</td> <td>6</td> <td>27</td> <td>53</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td style="text-align: left; padding: 5px;">Pilot in Command (PIC)</td> <td>732</td> <td>19</td> <td>732</td> <td></td> <td>6</td> <td>27</td> <td>53</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Time as Instructor</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #cccccc;"> <td style="text-align: left; padding: 5px;">This Make/Model</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 90 Days</td> <td>13</td> <td>7</td> <td>13</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 30 Days</td> <td>2.7</td> <td>1.4</td> <td>2.7</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 24 Hours</td> <td>.7</td> <td>.7</td> <td>.7</td> <td></td> <td>0</td> <td>0</td> <td>0</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 | 824 | 19 | 824 | 0 | 6 | 27 | 53 | 0 | 0 | 0 | Pilot in Command (PIC) | 732 | 19 | 732 |  | 6 | 27 | 53 |  |  |  | Time as Instructor | 0 | 0 | 0 |  |  |  |  |  |  |  | This Make/Model |  |  |  |  | 0 | 0 | 0 |  |  |  | Last 90 Days | 13 | 7 | 13 |  | 0 | 0 | 0 |  |  |  | Last 30 Days | 2.7 | 1.4 | 2.7 |  | 0 | 0 | 0 |  |  |  | Last 24 Hours | .7 | .7 | .7 |  | 0 | 0 | 0 |  |  |  |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 824          | 19                                                                                                                                                                                                                                                                                                                                         | 824                    | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6                                                                                                                                                                                                                                                       | 27                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 53                                                                                                                                                                                                                                        | 0          | 0      | 0                |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 732          | 19                                                                                                                                                                                                                                                                                                                                         | 732                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6                                                                                                                                                                                                                                                       | 27                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 53                                                                                                                                                                                                                                        |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0            | 0                                                                                                                                                                                                                                                                                                                                          | 0                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                           |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                                                                                                                                                                                                                                       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                                                                                                                                                                                                                                         |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 13           | 7                                                                                                                                                                                                                                                                                                                                          | 13                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                                                                                                                                                                                                                                       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                                                                                                                                                                                                                                         |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2.7          | 1.4                                                                                                                                                                                                                                                                                                                                        | 2.7                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                                                                                                                                                                                                                                       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                                                                                                                                                                                                                                         |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | .7           | .7                                                                                                                                                                                                                                                                                                                                         | .7                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0                                                                                                                                                                                                                                                       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0                                                                                                                                                                                                                                         |            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |     |    |     |   |   |    |    |   |   |   |                        |     |    |     |  |   |    |    |  |  |  |                    |   |   |   |  |  |  |  |  |  |  |                 |  |  |  |  |   |   |   |  |  |  |              |    |   |    |  |   |   |   |  |  |  |              |     |     |     |  |   |   |   |  |  |  |               |    |    |    |  |   |   |   |  |  |  |

| "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;">           Age at time of Accident/Incident: _____           Date of Birth: _____ mm/dd/yyyy         </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; 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 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>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student               </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport               </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer               </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign               </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           | <b>Date of Last Medical</b><br>_____ mm/dd/yyyy                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                                |                        |                                                                                                                                                                                                                 | <b>Medical Certificate Limitations</b><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           | <b>Medical Certificate Special Issuance</b><br><br>                                                                                                                                                                            |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____ mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b> <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; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Airplane Single-Engine<br/> <input type="checkbox"/> Airplane Multi-Engine<br/> <input type="checkbox"/> Gyroplane<br/> <input type="checkbox"/> Powered Lift               </div> <div> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport               </div> </div> |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Student Endorsements</b> <i>(Include dates)</i><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;">Flight Time <i>(Enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 5px;">Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr style="background-color: #d3d3d3;"> <td style="text-align: left; padding: 5px;">This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  | Flight Time <i>(Enter appropriate number of hours in each box)</i> | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time <i>(Enter appropriate number of hours in each box)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                               | Airplane Single Engine | Airplane Multiengine                                                                                                                                                                                            | Night                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |           | Rotorcraft                                                                                                                                                                                                                     | Glider | Lighter Than Air |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Simulated |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

| ADDITIONAL FLIGHT CREWMEMBERS (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                |                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                          | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                   |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                   |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> None</div> <div style="width: 33%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 33%;"><input type="checkbox"/> Commercial</div> <div style="width: 33%;"><input type="checkbox"/> US Military</div> <div style="width: 33%;"><input type="checkbox"/> Private</div> <div style="width: 33%;"><input type="checkbox"/> Recreational</div> <div style="width: 33%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 33%;"><input type="checkbox"/> Foreign</div> <div style="width: 33%;"><input type="checkbox"/> Student</div> <div style="width: 33%;"><input type="checkbox"/> Sport</div> <div style="width: 33%;"><input type="checkbox"/> Flight Engineer</div> </div> |                                                                                                                                          | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                   |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                          | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                |                                                                                                                                                                   |
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                          | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                   |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                   |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> None</div> <div style="width: 33%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 33%;"><input type="checkbox"/> Commercial</div> <div style="width: 33%;"><input type="checkbox"/> US Military</div> <div style="width: 33%;"><input type="checkbox"/> Private</div> <div style="width: 33%;"><input type="checkbox"/> Recreational</div> <div style="width: 33%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 33%;"><input type="checkbox"/> Foreign</div> <div style="width: 33%;"><input type="checkbox"/> Student</div> <div style="width: 33%;"><input type="checkbox"/> Sport</div> <div style="width: 33%;"><input type="checkbox"/> Flight Engineer</div> </div> |                                                                                                                                          | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown             </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                   |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                          | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                |                                                                                                                                                                   |
| PASSENGER(S) / OTHER PERSONNEL (Include cabin crew; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                |                                                                                                                                                                   |
| Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Seat                                                                                                                                     | Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Restraint Type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Inflatable Restraints                                                                                                                                                                                                          | Age                                                                                                                                                               |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <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;"> <div style="width: 50%;"> <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="width: 50%;"> <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <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;"> <div style="width: 50%;"> <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="width: 50%;"> <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <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;"> <div style="width: 50%;"> <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="width: 50%;"> <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <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;"> <div style="width: 50%;"> <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="width: 50%;"> <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>If Under 5,<br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |

| FLIGHT ITINERARY INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
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| <b>Last Departure Point</b><br>Airport ID: <u>KFNL</u><br>City: <u>Loveland</u><br>State: <u>CO</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Time of Departure</b><br>Time: <u>8:30 AM</u><br>Time Zone: <u>Mountair</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Destination</b><br>Airport ID: <u>KEIK</u><br>City: <u>Erie</u><br>State: <u>Co</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Type Flight Plan Filed</b><br><input checked="" type="radio"/> None <input type="radio"/> VFR/IFR<br><input type="radio"/> Company VFR <input type="radio"/> IFR<br><input type="radio"/> Military VFR <input type="radio"/> Unknown<br><input type="radio"/> VFR<br>Activated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                   |                                                                |
| <b>Type of ATC Clearance/Service</b> (Check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Special VFR</div> <div style="width: 50%;"><input type="checkbox"/> Special IFR</div> <div style="width: 50%;"><input type="checkbox"/> VFR Flight Following</div> <div style="width: 50%;"><input type="checkbox"/> Cruise</div> <div style="width: 50%;"><input checked="" type="checkbox"/> VFR</div> <div style="width: 50%;"><input type="checkbox"/> IFR</div> <div style="width: 50%;"><input type="checkbox"/> VFR On Top</div> <div style="width: 50%;"><input type="checkbox"/> Traffic Advisory</div> <div style="width: 50%;"><input type="checkbox"/> Unknown / NA</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Airspace where the accident/incident occurred</b> (Check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Class A</div> <div style="width: 33%;"><input checked="" type="checkbox"/> Class G</div> <div style="width: 33%;"><input type="checkbox"/> Military Operations Area (MOA)</div> <div style="width: 33%;"><input type="checkbox"/> Special</div> <div style="width: 33%;"><input type="checkbox"/> Class B</div> <div style="width: 33%;"><input type="checkbox"/> Demo Area</div> <div style="width: 33%;"><input type="checkbox"/> Airport Advisory Area</div> <div style="width: 33%;"><input type="checkbox"/> Air Traffic Control Area</div> <div style="width: 33%;"><input type="checkbox"/> Class C</div> <div style="width: 33%;"><input type="checkbox"/> Warning Area</div> <div style="width: 33%;"><input type="checkbox"/> Jet Training Area</div> <div style="width: 33%;"><input type="checkbox"/> Unknown</div> <div style="width: 33%;"><input type="checkbox"/> Class D</div> <div style="width: 33%;"><input type="checkbox"/> Prohibited Area</div> <div style="width: 33%;"><input type="checkbox"/> TRSA</div> <div style="width: 33%;"></div> <div style="width: 33%;"><input type="checkbox"/> Class E</div> <div style="width: 33%;"><input type="checkbox"/> Restricted Area</div> <div style="width: 33%;"><input type="checkbox"/> FAR 93</div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Altitude of In-Flight Occurrence:</b><br><u>5119</u> ft msl |
| WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Source of Pilot Weather Information</b><br>(Check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> National Weather Service</div> <div style="width: 50%;"><input type="checkbox"/> Company</div> <div style="width: 50%;"><input type="checkbox"/> Flight Service Station</div> <div style="width: 50%;"><input type="checkbox"/> Military</div> <div style="width: 50%;"><input type="checkbox"/> TV/Radio</div> <div style="width: 50%;"><input type="checkbox"/> Internet</div> <div style="width: 50%;"><input checked="" type="checkbox"/> Automated Report</div> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Commercial Weather Service (DUATS)</div> <div style="width: 50%;"><input type="checkbox"/> Unknown</div> <div style="width: 50%;"><input type="checkbox"/> On-Board Weather</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Weather Observation Facility</b><br>Facility ID: <u>KEIK</u><br>Observation Time: <u>9:10 AM</u><br>Time Zone: <u>Mountain</u><br>Distance from Accident Site: <u>.75</u> nm<br>Direction from Accident Site: <u>340</u> degrees true                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Sky/Lowest Cloud Condition</b><br><input checked="" type="radio"/> Clear <input type="radio"/> Thin Broken<br><input type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input type="radio"/> Unknown<br><input type="radio"/> Scattered<br><b>Lowest Cloud Condition Height</b><br>_____ ft agl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Ceiling</b><br><input checked="" type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input type="radio"/> Unknown<br><b>Ceiling Height</b><br>_____ ft agl                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Temperature:</b> _____ (C) or _____ (F)<br><b>Dew Point:</b> _____ (C) or _____ (F)<br><b>Altimeter Setting:</b> _____ in. Hg<br>or _____ MB                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Wind Direction</b><br><input type="checkbox"/> Variable<br>-or-<br>Direction: _____ degrees true                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Wind Speed</b><br><input checked="" type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>-or-<br>Speed: _____ kts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Wind Gusts</b><br><input checked="" type="checkbox"/> Not Gusting<br>-or-<br>Speed: _____ kts                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Visibility</b> _____ miles<br>RVR: _____ feet<br>RVV: _____ miles<br><b>Density Altitude:</b> _____ ft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Intensity of Precipitation</b><br><input type="radio"/> Light<br><input type="radio"/> Moderate<br><input type="radio"/> Heavy<br><input checked="" type="radio"/> N/A<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Type of Precipitation</b> (Check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input checked="" type="checkbox"/> None</div> <div style="width: 33%;"><input type="checkbox"/> Drizzle</div> <div style="width: 33%;"><input type="checkbox"/> Freezing Rain</div> <div style="width: 33%;"><input type="checkbox"/> Rain</div> <div style="width: 33%;"><input type="checkbox"/> Ice Pellets</div> <div style="width: 33%;"><input type="checkbox"/> Snow Shower</div> <div style="width: 33%;"><input type="checkbox"/> Snow</div> <div style="width: 33%;"><input type="checkbox"/> Snow Pellets</div> <div style="width: 33%;"><input type="checkbox"/> Ice Pellets Shower</div> <div style="width: 33%;"><input type="checkbox"/> Hail</div> <div style="width: 33%;"><input type="checkbox"/> Snow Grains</div> <div style="width: 33%;"><input type="checkbox"/> Freezing Drizzle</div> <div style="width: 33%;"><input type="checkbox"/> Rain Showers</div> <div style="width: 33%;"><input type="checkbox"/> Ice Crystals</div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Restriction to Visibility</b> (Check all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input checked="" type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Fog</div> <div style="width: 50%;"><input type="checkbox"/> Blowing Dust</div> <div style="width: 50%;"><input type="checkbox"/> Ground Fog</div> <div style="width: 50%;"><input type="checkbox"/> Blowing Sand</div> <div style="width: 50%;"><input type="checkbox"/> Haze</div> <div style="width: 50%;"><input type="checkbox"/> Blowing Snow</div> <div style="width: 50%;"><input type="checkbox"/> Ice Fog</div> <div style="width: 50%;"><input type="checkbox"/> Blowing Spray</div> <div style="width: 50%;"><input type="checkbox"/> Smoke</div> <div style="width: 50%;"><input type="checkbox"/> Dust</div> <div style="width: 50%;"><input type="checkbox"/> Unknown</div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |
| <b>Icing Forecast</b> <div style="display: flex;"> <div style="flex: 1;"> <b>Amount</b><br/> <input checked="" type="radio"/> None<br/> <input type="radio"/> Trace<br/> <input type="radio"/> Light<br/> <input type="radio"/> Moderate<br/> <input type="radio"/> Severe<br/> <input type="radio"/> Unknown               </div> <div style="flex: 1;"> <b>Type</b><br/> <input type="radio"/> N/A<br/> <input type="radio"/> Rime<br/> <input type="radio"/> Clear<br/> <input type="radio"/> Mixed<br/> <input type="radio"/> Unknown               </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Icing Actual</b> <div style="display: flex;"> <div style="flex: 1;"> <b>Amount</b><br/> <input checked="" type="radio"/> None<br/> <input type="radio"/> Trace<br/> <input type="radio"/> Light<br/> <input type="radio"/> Moderate<br/> <input type="radio"/> Severe<br/> <input type="radio"/> Unknown               </div> <div style="flex: 1;"> <b>Type</b><br/> <input type="radio"/> N/A<br/> <input type="radio"/> Rime<br/> <input type="radio"/> Clear<br/> <input type="radio"/> Mixed<br/> <input type="radio"/> Unknown               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Turbulence</b><br>Type (Check all that apply) <div style="display: flex;"> <div style="flex: 1;"> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Clear Air<br/> <input type="checkbox"/> Terrain-Induced<br/> <input type="checkbox"/> Convective Turbulence               </div> <div style="flex: 1;"> <b>Severity</b><br/> <input type="checkbox"/> Light<br/> <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Severe<br/> <input type="checkbox"/> Extreme               </div> </div> |                                                                |
| <b>NOTAMs (D and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident:</b><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                |

| DAMAGE TO AIRCRAFT AND OTHER PROPERTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Aircraft Damage</b><br><input type="radio"/> None <input type="radio"/> Substantial<br><input checked="" type="radio"/> Minor <input type="radio"/> Destroyed<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <b>Aircraft Fire</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Fire at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown |  | <b>Aircraft Explosion</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Explosion at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown |  |
| <b>Description of Damage to Aircraft and Other Property</b> <i>(Use additional sheet if necessary)</i><br><br>Right undercarriage collapsed.<br>Right wing fabric wrinkled.<br>Loss of engine RPM upon contact.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                        |  |
| NARRATIVE HISTORY OF FLIGHT <i>(Please type or print in ink)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                        |  |
| 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                        |  |
| I had departed from KFNL (Northern Colorado Regional) around 8:30 am and was taking the plane to Vector Air at KEIK (Erie, CO) for scheduled maintenance. The landing at KEIK was to be a full stop on runway 34 which was being used by others in the pattern. Weather was good and winds calm. The plane was in good working order. I had a stable approach and was planning on a wheel landing. At touchdown my tail was a bit low and I had a small bounce after which the plane veered slightly to the right. I tried to correct with left rudder feather but over corrected. Once the plane started left I lost rudder authority and the plane ground looped left of the runway and into a ditch. Time was around 9:30 AM. I was unhurt and proceeded to turn off the electronics and fuel. I then called on the CTAF to alert others in the pattern and the FBO. The FBO sent someone out and proceeded to organize lifting the plane, due to the right wheel collapse, and taking it to their maintenance hangar. |  |                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                        |  |

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

This accident was due to pilot error. Last October 2022 I had received five days of intensive training in the same make and model at Tac Aero in Oregon and was taught how to avoid and/or recover from this type of event. A wheel landing with tail low, which is what I did, is a good recipe for loss of rudder authority. In hindsight, I should have done a 3 point landing which is more forgiving in this aircraft and focused more on maintaining directional control. I should also have anticipated the possible issues and been ready to adjust with slight and occasional rudder adjustments rather than the strong and consistent rudder pressure done. Having the training, and/or additional training, closer to the accident timing would have been beneficial and will certainly be done following plane repairs.

**MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)**

Was there Mechanical Malfunction/Failure? ☐ Yes ☒ No  
(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)

**Total Time/Cycles  
On Part**

\_\_\_\_\_ Hours  
\_\_\_\_\_ Cycles

**Time Since This Part  
Inspected/Overhauled**

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**

**Fuel on Board at Last Takeoff**  
(Convert from pounds, as necessary)

19 \_\_\_\_\_ Gallons

**Fuel Type**

☐ 80/87 ☐ 115/145 ☐ Jet B ☐ Other, specify \_\_\_\_\_  
☒ 100 Low Lead ☐ Jet A ☐ JP8  
☐ 100/130 ☐ Jet A-1 ☐ Automotive

**Other Services, if Any, Prior to Departure**  
None

**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  
I exited via the only door, which was not damaged, in a safe and timely manner.

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

**Aircraft Registration Number**

**Manufacturer:** \_\_\_\_\_  
**Model:** \_\_\_\_\_

**Damage to Other Aircraft**

☐ Destroyed ☐ Minor  
☐ Substantial ☐ None

**Registered Owner of Other Aircraft**

Name: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Country: \_\_\_\_\_

**Pilot of Other Aircraft**

Name: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Country: \_\_\_\_\_

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

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

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

|                                                                      |                                                                                                                                                                                    |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of this Report</b><br><u>03/03/2023</u><br><i>mm/dd/yyyy</i> | <b>Name of Pilot/Operator:</b> <u>Edward H. Eggers</u><br><b>Signature:</b> <u>[Redacted]</u><br>-- or -- <input type="checkbox"/> Check here to electronically sign this document |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

If a Person Other than Pilot/Operator is Filing Report

|                                                                                   |                     |
|-----------------------------------------------------------------------------------|---------------------|
| <b>Name:</b> _____                                                                | <b>Title:</b> _____ |
| <b>Signature:</b> _____                                                           |                     |
| -- or -- <input type="checkbox"/> Check here to electronically sign this document |                     |

**FOR NTSB USE ONLY**

|                                                        |                                                                  |                                                   |                                                     |
|--------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|
| <b>NTSB Accident/Incident No.</b><br><b>CEN23LA123</b> | <b>Reviewed by NTSB Regional Office</b><br><b>Central Region</b> | <b>Name of Investigator</b><br><b>T. Sorensen</b> | <b>Date Report Received</b><br><b>March 3, 2023</b> |
|--------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|