

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

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

## BASIC INFORMATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>Mitchellville</u> State: <u>MD</u><br>ZIP: <u>20721</u> Country: <u>USA</u><br>Latitude: _____ (dd:mm:ss N/S) Longitude: _____ (ddd:mm:ss E/W)                                                                                                                                                                                                                                                                  |  | <b>Date/Time</b><br>Date: <u>09/02/2013</u> Local Time: <u>1540</u><br>mm/dd/yyyy Time Zone: <u>EDT</u>                                                                                             |  |
| <b>Phase of Operation</b><br><input type="checkbox"/> Standing <input checked="" type="checkbox"/> Takeoff (incl. initial climb) <input type="checkbox"/> Cruise <input type="checkbox"/> Hover<br><input type="checkbox"/> Taxi <input type="checkbox"/> Climb <input type="checkbox"/> Maneuvering <input type="checkbox"/> Other<br><input type="checkbox"/> Descent <input type="checkbox"/> Landing <input type="checkbox"/> Approach <input type="checkbox"/> Unknown |  | <b>Collision with Other Aircraft</b><br><input type="checkbox"/> Midair <input type="checkbox"/> On-ground <input type="checkbox"/> None<br><b>Altitude of In-Flight Occurrence</b><br>_____ ft MSL |  |

## AIRCRAFT INFORMATION

|                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Manufacturer:</b> <u>Mooney Aircraft Corp.</u><br><b>Model:</b> <u>M20</u><br><b>Serial Number:</b> <u>2140</u><br><b>Registration Number:</b> <u>N78951</u> <b>Amateur-built:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | <b>Max Gross Weight:</b> <u>2575</u> lbs<br><b>Weight at Time of Accident/Incident:</b> <u>2537</u> lbs<br><b>Location of Center of Gravity at Time of Accident/Incident:</b><br>_____ inches from <input type="checkbox"/> nose or <input type="checkbox"/> datum<br>-or- _____ Percent Mean Aerodynamic Cord (% MAC) |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Aircraft</b><br><input checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Blimp/Dirigible<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyrocraft<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered lift<br><input type="checkbox"/> Ultralight<br><input type="checkbox"/> Unknown | <b>Type of Airworthiness Certificate</b><br>(Check all that apply)<br><b>Standard</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Utility<br><input type="checkbox"/> Acrobatic<br><input type="checkbox"/> Transport<br><b>Special</b><br><input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Experimental<br><input type="checkbox"/> Special Flight<br><input type="checkbox"/> Light Sport | <b>Number of Seats:</b> <u>4</u><br>If Large Aircraft, how many seats for:<br>Flight Crew: _____<br>Cabin Crew: _____<br>Passengers: _____ | <b>Landing Gear</b> <input checked="" type="checkbox"/> Retractable<br>Check any additional landing gear configuration that applies:<br><input checked="" type="checkbox"/> Tricycle <input type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Unknown |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Type of Maintenance Program</b><br><input checked="" type="checkbox"/> Annual<br><input type="checkbox"/> Conditional (Amateur-built only)<br><input type="checkbox"/> Manufacturer's Inspection Program<br><input type="checkbox"/> Other Approved Inspection Program (AAIP)<br><input type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> Other, specify: _____ | <b>Last Inspection Type</b><br><input type="checkbox"/> 100 Hour <input type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> AAIP <input type="checkbox"/> Conditional Inspection<br><input checked="" type="checkbox"/> Annual <input type="checkbox"/> Unknown | <b>Date Last Inspection:</b> <u>11/9/2013</u><br>mm/dd/yyyy<br><b>Airframe Total Time:</b> <u>3702</u> hrs<br>hours measured at (check one)<br><input checked="" type="checkbox"/> Last Inspection <input type="checkbox"/> Time of Accident/Incident |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                             |                                                                                                                                               |                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>IFR Equipped</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | <b>Stall Warning System Installed</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <b>Type of Fire Extinguishing System</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Specify _____ |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                            |                                                                                  |                                                                                                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>ELT Installed</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                | <b>ELT Activated</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No | <b>ELT Manufacturer:</b> <u>Pointer</u><br><b>Model/Series:</b> <u>3000</u><br><b>Serial Number:</b> <u>300989</u><br><b>Battery Type:</b> <u>BPR30</u> <b>Battery Exp. Date:</b> <u>NOV 2013</u> |  |
| <b>ELT Aided in Locating Accident/Incident</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                  |                                                                                                                                                                                                   |  |

|                                                                                                                                                                                                                                                               |                                                                                                                                |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Engine Type</b><br><input checked="" type="checkbox"/> Reciprocating <input type="checkbox"/> Turbo Jet<br><input type="checkbox"/> Turbo Shaft <input type="checkbox"/> Turbo Fan<br><input type="checkbox"/> Turbo Prop <input type="checkbox"/> Unknown | <b>Reciprocating Fuel System Type</b><br><input checked="" type="checkbox"/> Carburetor <input type="checkbox"/> Fuel Injected | <b>Propeller</b><br><input type="checkbox"/> Fixed Pitch <input checked="" type="checkbox"/> Controllable Pitch<br>Manufacturer: _____<br>Model: _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg. mm/dd/yyyy | Engine Rated Power Measured as (check one)<br><input checked="" type="checkbox"/> Horsepower or <input type="checkbox"/> lbs of Thrust | Total Time (hours) | Time Since Inspection (hours) | Time Since Overhaul (hours) |
|--------|---------------------|---------------------|------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------|-----------------------------|
| Eng. 1 | Lycoming            | O&VO-360 SER        | 4794-36                      |                         | 180                                                                                                                                    | 3702               |                               |                             |
| Eng. 2 |                     |                     |                              |                         |                                                                                                                                        |                    |                               |                             |
| Eng. 3 |                     |                     |                              |                         |                                                                                                                                        |                    |                               |                             |
| Eng. 4 |                     |                     |                              |                         |                                                                                                                                        |                    |                               |                             |

| OWNER/OPERATOR INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Registered Aircraft Owner</b><br>Name: <u>ALIREZA TIVAY</u><br>Fractional Ownership Aircraft: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Owner Address</b><br>City: <u>Washington</u><br>State: <u>DC</u> ZIP: <u>20008</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): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Operator Address</b> <input checked="" type="checkbox"/> Same As Registered Owner<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Regulation Flight Conducted Under</b><br><input checked="" type="checkbox"/> FAR 91 <input type="checkbox"/> FAR 129 <input type="checkbox"/> FAR 91 Special Flight <input type="checkbox"/> Public Use (select type)<br><input type="checkbox"/> FAR 103 <input type="checkbox"/> FAR 133 <input type="checkbox"/> Non-US, Commercial <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local<br><input type="checkbox"/> FAR 121 <input type="checkbox"/> FAR 135 <input type="checkbox"/> Non-US, Non-commercial <input type="checkbox"/> Unknown<br><input type="checkbox"/> FAR 125 <input type="checkbox"/> FAR 137 <input type="checkbox"/> Armed Forces |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Revenue Sightseeing Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Air Medical Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Purpose of Flight</b><br>for FAR 91, 103, 133, 137 (Select one)<br><input checked="" type="checkbox"/> Personal<br><input type="checkbox"/> Business<br><input type="checkbox"/> Executive/Corporate<br><input type="checkbox"/> Other Work Use<br><input type="checkbox"/> Instructional<br><input type="checkbox"/> Ferry<br><input type="checkbox"/> Positioning<br><input type="checkbox"/> Aerial Application<br><input type="checkbox"/> Aerial Observation<br><input type="checkbox"/> Air Drop<br><input type="checkbox"/> Air Race / Show<br><input type="checkbox"/> Flight Test<br><input type="checkbox"/> Public Use<br><input type="checkbox"/> Unknown                                  | <b>Revenue Operation</b><br>for FAR 121, 125, 129, 135 (Select one)<br><input type="checkbox"/> Scheduled or Commuter<br><input type="checkbox"/> Non-Scheduled or Air Taxi<br><br><b>Domestic or International</b><br><input type="checkbox"/> Domestic <input type="checkbox"/> International<br><br><b>Cargo Operation</b><br><input type="checkbox"/> Passenger/Cargo<br><input type="checkbox"/> Passenger _____ How many?<br><input type="checkbox"/> Cargo _____ lbs<br><input type="checkbox"/> Mail | <b>Type of Commercial Operating Certificate Held</b><br>(Select all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (129)<br><input type="checkbox"/> Commuter Air Carrier (135)<br><input type="checkbox"/> On-Demand Air Taxi (135)<br><input type="checkbox"/> Large Helicopter (127)<br><input type="checkbox"/> Rotorcraft External Load (133)<br>- or -<br><input type="checkbox"/> Agricultural Aircraft (137)<br><input type="checkbox"/> Other Operator of Large Aircraft |
| OTHER AIRCRAFT – COLLISION (If air or ground collision occurred, complete this section for other aircraft)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Aircraft Registration Number _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Damage to Other Aircraft</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Registered Owner of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Pilot of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Was there Mechanical Malfunction/Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)<br><br><br><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Total Time/Cycles On Part</b><br>_____<br>Hours<br>_____<br>Cycles<br><br><b>Time Since This Part Inspected/Overhauled</b><br>_____<br>Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| DAMAGE TO AIRCRAFT AND OTHER PROPERTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Aircraft Damage</b><br><input type="checkbox"/> None <input checked="" type="checkbox"/> Substantial<br><input type="checkbox"/> Minor <input type="checkbox"/> Destroyed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Aircraft Fire</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                      | <b>Aircraft Explosion</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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

Substantial damage to aircraft. No damage to other property.

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

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

Distance From Airport Center: \_\_\_\_\_ SM

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

Direction From Airport: \_\_\_\_\_ degrees MAG

Proximity to Airport ☐ Off Airport/Airstrip ☐ On Airport ☐ On Airstrip

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

**Approach Segment** (Select one)☐ On Instrument Approach ☐ Landing ☐ Base leg ☐ Final ☐ Go Around  
☐ Crosswind ☐ Downwind ☐ Low Approach ☐ Aborted Landing (after touchdown)**IFR Approach** (Check all that apply)

|                                   |                                          |                                   |                                   |
|-----------------------------------|------------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> None     | <input type="checkbox"/> PAR             | <input type="checkbox"/> MLS      | <input type="checkbox"/> Practice |
| <input type="checkbox"/> ADF/NDB  | <input type="checkbox"/> Sidestep        | <input type="checkbox"/> LDA      | <input type="checkbox"/> GPS      |
| <input type="checkbox"/> SDF      | <input type="checkbox"/> ILS             | <input type="checkbox"/> ASR      | <input type="checkbox"/> Loran    |
| <input type="checkbox"/> VOR/TVOR | <input type="checkbox"/> Localizer Only  | <input type="checkbox"/> Visual   | <input type="checkbox"/> Unknown  |
| <input type="checkbox"/> VOR/DME  | <input type="checkbox"/> LOC-back course | <input type="checkbox"/> Contact  |                                   |
| <input type="checkbox"/> TACAN    | <input type="checkbox"/> RNAV            | <input type="checkbox"/> Circling |                                   |

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

|                                                   |                                                   |
|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Stop and Go              |
| <input type="checkbox"/> Traffic Pattern          | <input type="checkbox"/> Touch and Go             |
| <input type="checkbox"/> Straight-In              | <input type="checkbox"/> Simulated Forced Landing |
| <input type="checkbox"/> Valley/Terrain Following | <input type="checkbox"/> Forced Landing           |
| <input type="checkbox"/> Go Around                | <input type="checkbox"/> Precautionary Landing    |
| <input type="checkbox"/> Full Stop                | <input type="checkbox"/> Unknown                  |

**Runway Information**

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

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

|                                   |                                     |                                     |                                  |
|-----------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Asphalt  | <input type="checkbox"/> Grass/Turf | <input type="checkbox"/> Macadam    | <input type="checkbox"/> Water   |
| <input type="checkbox"/> Concrete | <input type="checkbox"/> Gravel     | <input type="checkbox"/> Metal/Wood | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Dirt     | <input type="checkbox"/> Ice        | <input type="checkbox"/> Snow       |                                  |

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

|                                          |                                         |                                       |
|------------------------------------------|-----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dry             | <input type="checkbox"/> Snow-Compacted | <input type="checkbox"/> Water-Calm   |
| <input type="checkbox"/> Holes           | <input type="checkbox"/> Snow-Crusted   | <input type="checkbox"/> Water-Choppy |
| <input type="checkbox"/> Ice Covered     | <input type="checkbox"/> Snow-Dry       | <input type="checkbox"/> Water-Glassy |
| <input type="checkbox"/> Rough           | <input type="checkbox"/> Snow-Wet       | <input type="checkbox"/> Wet          |
| <input type="checkbox"/> Rubber Deposits | <input type="checkbox"/> Soft           | <input type="checkbox"/> Unknown      |
| <input type="checkbox"/> Slush Covered   | <input type="checkbox"/> Vegetation     |                                       |

**FLIGHT ITINERARY INFORMATION****Last Departure Point**

Airport ID: W00

City: Mitchellville

State: MD

Country: USA

**Time of Departure**

Time: 1540

Time Zone: EDT

**Destination**

Airport ID: unknown

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

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

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

**Type Flight Plan Filed**

|                                       |                                             |
|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> None         | <input type="checkbox"/> VFR/IFR            |
| <input type="checkbox"/> Company VFR  | <input type="checkbox"/> IFR                |
| <input type="checkbox"/> Military VFR | <input checked="" type="checkbox"/> Unknown |
| <input type="checkbox"/> VFR          |                                             |

Activated? ☐ Yes ☐ No**Type of ATC Clearance/Service** (Check all that apply)

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

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

|                                  |                                             |                                                         |                                            |                                                   |
|----------------------------------|---------------------------------------------|---------------------------------------------------------|--------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Class A | <input type="checkbox"/> Class E            | <input type="checkbox"/> Prohibited Area                | <input type="checkbox"/> Jet Training Area | <input checked="" type="checkbox"/> Special       |
| <input type="checkbox"/> Class B | <input checked="" type="checkbox"/> Class G | <input type="checkbox"/> Restricted Area                | <input type="checkbox"/> TRSA              | <input type="checkbox"/> Air Traffic Control Area |
| <input type="checkbox"/> Class C | <input type="checkbox"/> Demo Area          | <input type="checkbox"/> Military Operations Area (MOA) | <input type="checkbox"/> FAR 93            | <input type="checkbox"/> Unknown                  |
| <input type="checkbox"/> Class D | <input type="checkbox"/> Warning Area       | <input type="checkbox"/> Airport Advisory Area          |                                            |                                                   |

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

|                                                |                                         |                                                    |                                    |
|------------------------------------------------|-----------------------------------------|----------------------------------------------------|------------------------------------|
| <input type="checkbox"/> None                  | <input type="checkbox"/> Towing Glider  | <input type="checkbox"/> Parachutists              | <input type="checkbox"/> Livestock |
| <input checked="" type="checkbox"/> Passengers | <input type="checkbox"/> Towing Banner  | <input type="checkbox"/> Water                     | <input type="checkbox"/> Unknown   |
| <input type="checkbox"/> Cargo                 | <input type="checkbox"/> Other External | <input type="checkbox"/> Chemical/Fertilizer/Seeds |                                    |

**FUEL & SERVICES INFORMATION****Fuel on Board at Last Takeoff**

(convert from pounds, as necessary)

\_\_\_\_\_ 55 Gallons

**Fuel Type**

|                                                  |                                     |                              |                                               |
|--------------------------------------------------|-------------------------------------|------------------------------|-----------------------------------------------|
| <input type="checkbox"/> 80/87                   | <input type="checkbox"/> 115/145    | <input type="checkbox"/> JP3 | <input type="checkbox"/> Other, specify _____ |
| <input checked="" type="checkbox"/> 100 Low Lead | <input type="checkbox"/> Jet A      | <input type="checkbox"/> JP4 |                                               |
| <input type="checkbox"/> 100/130                 | <input type="checkbox"/> Automotive | <input type="checkbox"/> JP5 |                                               |

Other Services, if Any, Prior to Departure

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

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

**WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE****Weather Observation Facility**

Facility ID: \_\_\_\_\_

Observation Time: \_\_\_\_\_

Time Zone: \_\_\_\_\_

Distance from Accident Site: \_\_\_\_\_ NM

Direction from Accident Site: \_\_\_\_\_ degrees MAG

**Source of Weather Information**

(Check all that apply)

☒ National Weather Service☐ Flight Service Station☐ TV/Radio☐ Automated Report☒ Commercial Weather Service (DUATS)☐ Company☐ Military☐ Internet☐ Unknown**Method of Briefing**

(Check all that apply)

☐ In Person☐ Teletype☒ Telephone/Computer☐ Aircraft Radio☐ TV/Radio☐ Unknown**Briefing Type/Completeness**☒ Full☐ Partial / Limited By Pilot☐ Partial / Limited By Briefer☐ Abbreviated☐ Unknown☐ Not Pertinent**Light Condition**☐ Dawn☐ Day☐ Dusk☐ Night☐ Dark Night☐ Bright Night☐ Not Reported**Visibility**

\_\_\_\_\_ miles

**Sky/Lowest Cloud Condition**☐ Clear☐ Few☐ Partial Obscuration☐ Scattered☐ Thin Broken☐ Thin Overcast☐ Unknown**Ceiling**☐ None (clear)☐ Broken☐ Overcast☐ Obscured☐ Indefinite☐ Unknown**Restriction to Visibility (Check all that apply)**☐ None☐ Blowing Dust☐ Blowing Sand☐ Blowing Snow☐ Blowing Spray☐ Dust☐ Fog☐ Ground Fog☐ Haze☐ Ice Fog☐ Smoke☐ Unknown**Lowest Cloud Condition Height**

\_\_\_\_\_ ft AGL

**Ceiling Height**

\_\_\_\_\_ ft AGL

**Wind Direction**☐ Indicated:

\_\_\_\_\_ degrees MAG

☐ Variable**Wind Speed**

Velocity: \_\_\_\_\_ KTS

-or-

☐ Calm☐ Light and Variable**Wind Gusts**

Velocity: \_\_\_\_\_ KTS

☐ Gusting☐ Not Gusting**Type of Turbulence (Check all that apply)**☐ None☐ Clear Air☐ In Clouds☐ Vicinity of Thunderstorm**Severity of Turbulence**☐ Extreme☐ Severe☐ Moderate☐ Moderate Chop☐ Light

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

Temperature: \_\_\_\_\_ (C)

or 90 (F)

Altimeter Setting: \_\_\_\_\_ in. HG

or \_\_\_\_\_ MB

Density Altitude: \_\_\_\_\_ ft

Dew Point: \_\_\_\_\_ (C)

or \_\_\_\_\_ (F)

**Icing Forecast**

Amount

☐ None☐ Trace☐ Light☐ Moderate☐ Severe

Type

☐ Rime☐ Clear☐ Mixed**Icing Actual**

Amount

☐ None☐ Trace☐ Light☐ Moderate☐ Severe

Type

☐ Rime☐ Clear☐ Mixed**Type of Precipitation (Check all that apply)**☐ None☐ Rain☐ Snow☐ Hail☐ Rain Showers☐ Freezing Rain☐ Snow Shower☐ Drizzle☐ Ice Pellets☐ Snow Pellets☐ Snow Grains☐ Ice Crystals☐ Ice Pellets Shower☐ Freezing Drizzle**Intensity of Precipitation**☐ Light☐ Moderate☐ Heavy

### Pilot "A" Responsibilities at the Time of Accident/Incident

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

| <b>ADDITIONAL FLIGHT CREW MEMBERS</b> (Exclusive of cabin attendants, complete the following information)                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------|---------|--------------|-----|-------|----------------|--------------|-----------|---------|
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |      |             |         |              |     |       |                |              |           |         |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |      |             |         |              |     |       |                |              |           |         |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                   |      |             |         |              |     |       |                |              |           |         |
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |      |             |         |              |     |       |                |              |           |         |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |      |             |         |              |     |       |                |              |           |         |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                   |      |             |         |              |     |       |                |              |           |         |
| <b>Pilot Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  | <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                              |      |             |         |              |     |       |                |              |           |         |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |      |             |         |              |     |       |                |              |           |         |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                   |      |             |         |              |     |       |                |              |           |         |
| <b>PASSENGER(S) / OTHER PERSONNEL</b> (Include flight attendants; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  | Seat                                                                                                                                                                                                                                                        | Crew | Non-Revenue | Revenue | Non-Occupant | FAA | Fatal | Serious Injury | Minor Injury | No Injury | Unknown |
| First Name: Deborah City: Washington<br>Middle Initial: Ann State: DC ZIP: 20010<br>Last Name: Tucker Country: USA                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  | right                                                                                                                                                                                                                                                       |      |             |         |              |     |       |                |              |           |         |
| First Name: Seth City: _____<br>Middle Initial: _____ State: MD ZIP: _____<br>Last Name: Sharpe Country: _____                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  | rear                                                                                                                                                                                                                                                        |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |
| First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |                                                                                                                                                                                                                                                             |      |             |         |              |     |       |                |              |           |         |

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

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

Have no recollection of the accident.

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

Operator/Owner Safety Recommendation

Unknown

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

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

n/a

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE****Date of this Report**      **Signature and Name of Pilot/Operator**\_\_\_\_\_  
mm/dd/yyyy

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

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

**Signature and Name of Person Filing Report if Other than Pilot/Operator**

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

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

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

**FOR NTSB USE ONLY****NTSB Accident/Incident No.**

ERA13LA391

**Reviewed by NTSB Regional Office**

ERA (NJ)

**Name of Investigator**

Gretz

**Date Report Received**

2/13/14