

| <b>NATIONAL TRANSPORTATION SAFETY BOARD</b><br><b>PILOT/OPERATOR AIRCRAFT ACCIDENT/INCIDENT REPORT</b><br><b>This form to be used for reporting civil and public use aircraft accidents and incidents</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|---------------------|---------------------|------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------------------|-----------------------------|--------|-----------------|------------------|--------------------|----------------|------------|-------------|------------|-------------|--------|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|
| <b>BASIC INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>REPUBLIC AIRPORT KFRU</u> State: <u>NY</u><br>ZIP: <u>11731</u> Country: _____<br>Latitude: _____ (dd-mm-ss N/S) Longitude: _____ (dd-mm-ss E/W)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        | <b>Date/Time</b><br>Date: <u>08-17-2014</u> Local Time: <u>1430</u> <u>APX</u><br><small>mm/dd/yyyy</small><br>Time Zone: <u>EDT</u>                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <b>Phase of Operation</b><br><input type="checkbox"/> Standing <input type="checkbox"/> Takeoff (incl. initial climb) <input checked="" 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 checked="" type="checkbox"/> Descent <input type="checkbox"/> Landing <input type="checkbox"/> Approach <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        | <b>Collision with Other Aircraft</b><br><input type="checkbox"/> Midair<br><input type="checkbox"/> On-ground<br><input checked="" type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                         |                               | <b>Altitude of In-Flight Occurrence</b><br>_____ ft MSL |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <b>Manufacturer:</b> <u>CESSNA</u><br><b>Model:</b> <u>R182</u><br><b>Serial Number:</b> <u>R182-01188</u><br><b>Registration Number:</b> <u>N292LC</u> Amateur-built: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        | <b>Max Gross Weight:</b> <u>3100</u> lbs<br><b>Weight at Time of Accident/Incident:</b> <u>2680</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><small>(Check all that apply)</small><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>2-15-14</u><br><small>mm/dd/yyyy</small><br><b>Airframe Total Time:</b> <u>3950</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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Stall Warning System Installed</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                      |                                                                                                                                            |                                                                                                                                        | <b>Type of Fire Extinguishing System</b><br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Specify <u>PORTABLE HAND</u>                                                                                                                                                                                                                                                                                                                                                                                                     |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <b>ELT Installed</b> <b>ELT Activated</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>ELT Manufacturer:</b> <u>ARCLOC INC</u><br><b>Model/Series:</b> _____<br><b>Serial Number:</b> _____<br><b>Battery Type:</b> <u>0314</u> <b>Battery Exp. Date:</b> <u>02-16</u>                                                                                                 |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <b>ELT Aided in Locating Accident/Incident</b><br><input type="checkbox"/> Yes <input checked="" 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<br><input type="checkbox"/> Fuel Injected                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                                         | <b>Propeller</b><br><input type="checkbox"/> Fixed Pitch<br><input checked="" type="checkbox"/> Controllable Pitch |  |  | <b>Manufacturer:</b> <u>MACAULEY</u><br><b>Model:</b> <u>C240 D36 C433 B</u> |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Engine</th> <th>Engine Manufacturer</th> <th>Engine Model/Series</th> <th>Manufacturer's Serial Number</th> <th>Date of Mfg.<br/><small>mm/dd/yyyy</small></th> <th>Engine Rated Power Measured as (check one)<br/><input checked="" type="checkbox"/> Horsepower or <input type="checkbox"/> lbs of Thrust</th> <th>Total Time (hours)</th> <th>Time Since Inspection (hours)</th> <th>Time Since Overhaul (hours)</th> </tr> </thead> <tbody> <tr> <td>Eng. 1</td> <td><u>LYCOMING</u></td> <td><u>0540534FD</u></td> <td><u>L21622-40 A</u></td> <td><u>3-12-03</u></td> <td><u>235</u></td> <td><u>1800</u></td> <td><u>150</u></td> <td><u>1800</u></td> </tr> <tr> <td>Eng. 2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Eng. 3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Eng. 4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  | Engine                                                                       | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br><small>mm/dd/yyyy</small> | 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 | <u>LYCOMING</u> | <u>0540534FD</u> | <u>L21622-40 A</u> | <u>3-12-03</u> | <u>235</u> | <u>1800</u> | <u>150</u> | <u>1800</u> | Eng. 2 |  |  |  |  |  |  |  |  | Eng. 3 |  |  |  |  |  |  |  |  | Eng. 4 |  |  |  |  |  |  |  |  |
| Engine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Engine Manufacturer | Engine Model/Series                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Manufacturer's Serial Number                                                                                                                                                                                                                                                       | Date of Mfg.<br><small>mm/dd/yyyy</small>                                                                                                  | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>LYCOMING</u>     | <u>0540534FD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>L21622-40 A</u>                                                                                                                                                                                                                                                                 | <u>3-12-03</u>                                                                                                                             | <u>235</u>                                                                                                                             | <u>1800</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <u>150</u>                    | <u>1800</u>                                             |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| Eng. 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| Eng. 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |
| Eng. 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                         |                                                                                                                    |  |  |                                                                              |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |        |                 |                  |                    |                |            |             |            |             |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |        |  |  |  |  |  |  |  |  |



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

EXTENSIVE DAMAGE TO ENGINE BAY & OUTER HULL FROM IN-FLIGHT FIRE  
 & SUBSEQUENT GROUND FIRE DURING EXTINGUISHING ATTEMPT  
 EXTENSIVE INTERNAL SMOKE DAMAGE + DAMAGE FROM FIRE-FIGHTING

## ACFT &amp; RT INFORMATION (in the event of an accident or incident, check all that apply)

Airport Identifier: KFRG Distance From Airport Center: SM  
 Airport Name: REPUBLIC FARMINGDALE NY Direction From Airport: degrees MAG  
 Proximity to Airport ☐ Off Airport/Airstrip ☒ On Airport ☐ On Airstrip Airport Elevation: 76 ft. MSL

## Approach Segment (Select one)

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

## IFR Approach (Check all that apply)

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

## VFR Approach (Check all that apply)

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

## Runway Information

Runway ID: 32 (L/R/C) Length: 6833 ft Width: 150 ft

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

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

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

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

## FLIGHT INFORMATION

Last Departure Point  
 Airport ID: KFRG  
 City: FARMINGDALE  
 State: NY  
 Country: USA

Time of Departure  
 Time: 1415 LOCAL  
 Time Zone: EDT

Destination  
 Airport ID: KPOU  
 City: POUGHKEEPSIE  
 State: NY  
 Country: USA

Type Flight Plan Filed  
☐ None ☐ VFR/IFR  
☐ Company VFR ☒ IFR  
☐ Military VFR ☐ Unknown  
☐ VFR  
 Activated? ☐ Yes ☐ No

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

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

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

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

## Aircraft Load Description (Check all that apply)

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

## FUEL &amp; SERVICES INFORMATION

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

56 Gallons

## Fuel Type

☐ 80/87 ☐ 115/145 ☐ JP3 ☐ Other, specify \_\_\_\_\_  
☒ 100 Low Lead ☐ Jet A ☐ JP4  
☐ 100/130 ☐ Automotive ☐ JP5

## Other Services, if Any, Prior to Departure

|                                                                                                                                                                                                                                                                                                                     |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Was an emergency evacuation of the aircraft performed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Method of Exit</b> - Describe how the occupants exited and how many occupants evacuated each location<br><div style="text-align: center; font-family: monospace; font-size: 1.2em;">         2 OCCUPANTS EXITED FROM PILOT &amp; CO-PILOT DOORS<br/>         RESPECTIVELY       </div>                           |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE</b>                                                                                                                                                                                                                                                            |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Weather Observation Facility</b><br>Facility ID: <u>KFRG</u><br>Observation Time: <u>APR 1355 INFO RAY</u><br>Time Zone: <u>EDT</u><br>Distance from Accident Site: <u>-0-</u> NM<br>Direction from Accident Site: <u>-0-</u> degrees MAG                                                                        |                                                                                                                                     | <b>Source of Weather Information</b><br>(Check all that apply)<br><input type="checkbox"/> National Weather Service<br><input type="checkbox"/> Flight Service Station<br><input type="checkbox"/> TV/Radio<br><input type="checkbox"/> Automated Report<br><input type="checkbox"/> Commercial Weather Service (DUATS)<br><input type="checkbox"/> Company<br><input type="checkbox"/> Military<br><input checked="" type="checkbox"/> Internet<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Briefing Type/Completeness</b><br><input checked="" type="checkbox"/> Full<br><input type="checkbox"/> Partial / Limited By Pilot<br><input type="checkbox"/> Partial / Limited By Briefer<br><input type="checkbox"/> Abbreviated<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> Not Pertinent |                                                                                                                                     | <b>Light Condition</b><br><input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark Night<br><input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Bright Night<br><input type="checkbox"/> Not Reported                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Sky/Lowest Cloud Condition</b><br><input type="checkbox"/> Clear <input type="checkbox"/> Thin Broken<br><input type="checkbox"/> Few <input type="checkbox"/> Thin Overcast<br><input type="checkbox"/> Partial Obscuration <input type="checkbox"/> Unknown<br><input checked="" type="checkbox"/> Scattered   |                                                                                                                                     | <b>Restriction to Visibility</b> (Check all that apply)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> Fog<br><input type="checkbox"/> Blowing Dust <input type="checkbox"/> Ground Fog<br><input type="checkbox"/> Blowing Sand <input type="checkbox"/> Haze<br><input type="checkbox"/> Blowing Snow <input type="checkbox"/> Ice Fog<br><input type="checkbox"/> Blowing Spray <input type="checkbox"/> Smoke<br><input type="checkbox"/> Dust <input type="checkbox"/> Unknown                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Lowest Cloud Condition Height</b><br><u>3500</u> ft AGL                                                                                                                                                                                                                                                          |                                                                                                                                     | <b>Ceiling Height</b><br><u>12000+</u> ft AGL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Wind Direction</b><br><input type="checkbox"/> Indicated:<br><u>360</u> degrees MAG<br><u>5 KTS</u><br><input type="checkbox"/> Variable                                                                                                                                                                         | <b>Wind Speed</b><br>Velocity: <u>5</u> KTS<br>-or-<br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable | <b>Wind Gusts</b><br>Velocity: _____ KTS<br><input type="checkbox"/> Gusting<br><input checked="" type="checkbox"/> Not Gusting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Type of Turbulence</b> (Check all that apply)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> In Clouds<br><input type="checkbox"/> Clear Air <input type="checkbox"/> Vicinity of Thunderstorm<br><b>Severity of Turbulence</b><br><input type="checkbox"/> Extreme <input type="checkbox"/> Moderate <input type="checkbox"/> Light<br><input type="checkbox"/> Severe <input type="checkbox"/> Moderate Chop |
| <b>NOTAMs (D, L and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident</b><br><div style="text-align: center; font-family: monospace; font-size: 1.2em;">         NONE APPLICABLE       </div>                                                                                           |                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Temperature:</b> _____ (C)<br>or <u>75</u> (F) <u>APPX</u><br><b>Altitude Setting:</b> <u>2983</u> in HG<br>or _____ MB<br><b>Density Altitude:</b> _____ ft<br><b>Dew Point:</b> _____ (C)<br>or _____ (F)                                                                                                      |                                                                                                                                     | <b>Icing Forecast</b><br>Amount: <input checked="" type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe<br><input type="checkbox"/> Trace <input type="checkbox"/> Light<br>Type: <input type="checkbox"/> Rime <input type="checkbox"/> Clear <input type="checkbox"/> Mixed<br><b>Icing Actual</b><br>Amount: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe<br><input type="checkbox"/> Trace <input type="checkbox"/> Light<br>Type: <input type="checkbox"/> Rime <input type="checkbox"/> Clear <input type="checkbox"/> Mixed                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                     |                                                                                                                                     | <b>Type of Precipitation</b> (Check all that apply)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> Drizzle<br><input type="checkbox"/> Rain <input type="checkbox"/> Ice Pellets<br><input type="checkbox"/> Snow <input type="checkbox"/> Snow Pellets<br><input type="checkbox"/> Hail <input type="checkbox"/> Snow Grains<br><input type="checkbox"/> Rain Showers <input type="checkbox"/> Ice Crystals<br><input type="checkbox"/> Freezing Rain <input type="checkbox"/> Ice Pellets Shower<br><input type="checkbox"/> Snow Shower <input type="checkbox"/> Freezing Drizzle<br><b>Intensity of Precipitation</b><br><input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy |                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| PILOT "A" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------|-------------------------------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|--|------------|--------|------------------|--------|-----------|------------|------|------|------|---|-----|-----|----|--|--|--|------------------------|------|------|------|---|-----|-----|----|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--------------|----|----|----|--|---|----|--|--|--|--|--------------|----|----|----|--|--|----|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|--|
| <b>Pilot "A" Responsibilities at the Time of Accident/Incident</b><br><input checked="" type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot "A" Identification</b><br>First Name: <u>JEFFREY</u> City: <u>W. HEMPSTEAD</u><br>Middle Initial: <u>B</u> State: <u>NY</u> ZIP: <u>11552</u><br>Last Name: <u>CAIPELINE</u> Country: <u>USA</u><br>Age at time of Accident/Incident: <u>55</u> Date of Birth: <u>                    </u> Certificate Number: <u>                    </u><br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                               | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input checked="" type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single                                                                         |                      |                                                                                                                                                                                                 | <b>Seat Belt</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No                                                     |                                                                                                                         | <b>Shoulder Harness</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input 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 checked="" 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 checked="" type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input checked="" 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 checked="" type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                        | <b>Date of Last Medical</b><br><u>11/12/2012</u><br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b><br><u>EYES/ASSCS</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Waivers</b><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>03/20/2014</u><br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      | <b>Flight Review Aircraft</b><br>Make: <u>CESSNA</u><br>Model: <u>R 182</u>                                                                                                                     |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                               | <b>Other Aircraft Rating(s)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> 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 checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                         | <b>Instructor Rating(s)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None<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; font-size: small;"> <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>2738</td> <td>2295</td> <td>2738</td> <td>2</td> <td>372</td> <td>496</td> <td>97</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pilot in Command (PIC)</td> <td>2646</td> <td>2295</td> <td>2646</td> <td>2</td> <td>372</td> <td>496</td> <td>97</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>53</td> <td>53</td> <td>53</td> <td></td> <td>4</td> <td>17</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Last 30 Days</td> <td>28</td> <td>28</td> <td>28</td> <td></td> <td></td> <td>10</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 | 2738 | 2295 | 2738 | 2 | 372 | 496 | 97 |  |  |  | Pilot in Command (PIC) | 2646 | 2295 | 2646 | 2 | 372 | 496 | 97 |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days | 53 | 53 | 53 |  | 4 | 17 |  |  |  |  | Last 30 Days | 28 | 28 | 28 |  |  | 10 |  |  |  |  | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2738         | 2295                                                                                                                                                                                                                                                                          | 2738                                                                                                                                                                                                                                                                                                                                        | 2                    | 372                                                                                                                                                                                             | 496                                                                                                                                                                                                                    | 97                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2646         | 2295                                                                                                                                                                                                                                                                          | 2646                                                                                                                                                                                                                                                                                                                                        | 2                    | 372                                                                                                                                                                                             | 496                                                                                                                                                                                                                    | 97                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 53           | 53                                                                                                                                                                                                                                                                            | 53                                                                                                                                                                                                                                                                                                                                          |                      | 4                                                                                                                                                                                               | 17                                                                                                                                                                                                                     |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 28           | 28                                                                                                                                                                                                                                                                            | 28                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                 | 10                                                                                                                                                                                                                     |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                 |                                                                                                                                                                                                                        |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |      |      |   |     |     |    |  |  |  |                        |      |      |      |   |     |     |    |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |    |    |    |  |   |    |  |  |  |  |              |    |    |    |  |  |    |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

| <b>Pilot Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          | <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                                                       |                                       |                                        |              |           |         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------|--------------|-----------|---------|
| First Name: _____<br>Middle Initial: _____<br>Last Name: _____                                                                                                                                                                                                                                                                                                                                                                                                    | City: _____<br>State: _____ ZIP: _____<br>Country: _____ |                                                                                                                                                                                                                                                      |                                       |                                        |              |           |         |
| Pilot Certificate(s) (Check all that apply)<br><input type="checkbox"/> Nonc <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 |                                                          | Seat Occupied<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 |                                       |                                        |              |           |         |
| Type Rating/Endorsement for Accident/Incident Aircraft? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |                                                          | Total Flight Time at the Time of this Accident/Incident: _____ hrs                                                                                                                                                                                   |                                       |                                        |              |           |         |
| First Name: _____<br>Middle Initial: _____<br>Last Name: _____                                                                                                                                                                                                                                                                                                                                                                                                    | City: _____<br>State: _____ ZIP: _____<br>Country: _____ |                                                                                                                                                                                                                                                      |                                       |                                        |              |           |         |
| Pilot Certificate(s) (Check all that apply)<br><input type="checkbox"/> Nonc <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 |                                                          | Seat Occupied<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 |                                       |                                        |              |           |         |
| Type Rating/Endorsement for Accident/Incident Aircraft? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |                                                          | Total Flight Time at the Time of this Accident/Incident: _____ hrs                                                                                                                                                                                   |                                       |                                        |              |           |         |
| First Name: _____<br>Middle Initial: _____<br>Last Name: _____                                                                                                                                                                                                                                                                                                                                                                                                    | City: _____<br>State: _____ ZIP: _____<br>Country: _____ |                                                                                                                                                                                                                                                      |                                       |                                        |              |           |         |
| Pilot Certificate(s) (Check all that apply)<br><input type="checkbox"/> Nonc <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 |                                                          | Seat Occupied<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 |                                       |                                        |              |           |         |
| Type Rating/Endorsement for Accident/Incident Aircraft? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  |                                                          | Total Flight Time at the Time of this Accident/Incident: _____ hrs                                                                                                                                                                                   |                                       |                                        |              |           |         |
| Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                          | Seat                                                                                                                                                                                                                                                 | Crew<br><small>(Non-Occupant)</small> | Fatal<br><small>Serious Injury</small> | Minor Injury | No Injury | Unknown |
| First Name: DAVID<br>Middle Initial: R<br>Last Name: HERTZ                                                                                                                                                                                                                                                                                                                                                                                                        | City: OYERBAY<br>State: NY ZIP: 11771<br>Country: USA    | L                                                                                                                                                                                                                                                    | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |
| First Name:<br>Middle Initial:<br>Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                      | City:<br>State: ZIP:<br>Country:                         |                                                                                                                                                                                                                                                      | □ □ □ □ □ □                           | □ □ □ □ □ □                            | □ □ □ □ □ □  |           |         |

# DESCRIPTION OF FLIGHT

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.

DEPARTED KFRG 1415 IFR FP IN VFR - CLEARED TO 7000 DESTINATION KPOO - APT 56 GA/ 100LL  
 ABOARD - NO SERVICES. NBOUND NY DEPARTURE CLEARS US TO 5000. SHORTLY AFTER LEAVING 5000  
 NOTED FUEL PRESSURE DROP 0.2 PSI & FLOW RATE INCREASE. CALLED NY DEPARTURE TO  
 ALERT THEM TO PROBLEM WHICH WE THOUGHT WAS INSTRUMENTATION (PAPR ENGINE ANALYZER HAD  
 GIVEN MANY SUCH FALSE READINGS IN YEARS PAST) WE REQUESTED RETURN TO KFRG W/ PRIORITY. NO  
 EMERGENCY DECLARED AS ENGINE RAN FINE & WE WERE RETURNING FOR A PRECAUTIONARY LANDING.  
 MAINTAINED 5000 TILL AIRPORT WAS MADE. DESCENDED 3000 CLEARED VLSUA/32 HANDLED OFF FGS TOWER.  
 WE WERE ON A HIGH PT DOWNWIND TO BASE WHEN SMOKE APPEARED IN COCKPIT - ACARD INSULATION SHEET/WHICH  
 WE THOUGHT WAS ELECTRICAL IN ORIGIN. DECLARED EMERGENCY & ASKED GEAR TO BE RAISED - GAVE FUEL  
 & OILS ONBOARD & CUT POWER - ENGINE RAN NORMALLY. AT 1000 - WE HAD FLAMES COMING INTO COCKPIT FROM  
 RUDDER PEDAL AREA. TURNED ON POWER TO LOWER GEAR AS WE WERE AFRAID FIRE WOULD BURN THRU  
 HYDRAULIC LINES - LOWERED FLAPS & MAINTAINED 14. LANDED 32 & TURNED OFF ON THE WAY.  
 WE HAD BRIEFED THE EGRESS & EVAL PROCEDURE ON THE WAY DOWN & IT WENT AS WELL AS  
 COULD BE HOPED. WAITED TO ROLL TO A HARD STOP & PROP CUT OFF & STOPPED BEFORE EVAL TO  
 KEEP FLAMES FROM BEING BLOWN INTO OUR EGRESS. FIRETRUCK WAS POSITIONED QUICKLY  
 & WE RAN UPWIND BEHIND TRUCK - FIRE OPS DROPPED UP HI PRESSURE CANON W/ FAN.  
 2ND TRUCK JOINED SOON AFTER. FLASH SOIT FIREFIGHTER W/ HAND NOSE LINE SUCCEEDED  
 IN EXTINGUISHING FLAMES IN APPROX 10-15 MINUTES

## RECOMMENDATION How could the investigation have been prevented?

### Operator/Owner Safety Recommendation

TURN BACK AT 1<sup>ST</sup> SIGN OF TROUBLE. DO NOT "KEEP AN EYE ON IT" IF YOU GET  
 ANY ANOMALOUS INDICATIONS. WE DIDN'T HAVE MUCH TIME LEFT BEFORE THE  
 STRUCTURE WOULD HAVE FAILED.

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

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

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

Date of this Report

08/21/2014

mm/dd/yyyy

Signature and Name of Pilot/Operator

Signature: [REDACTED]

Type or Print Name: JEFFREY D. CHAPETINE

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.

ERA14LA390

Reviewed by NTSB Regional Office

ERA

Name of Investigator

COX

Date Report Received

9-2-2014

8/17/14 1600

N292 LG  
CESSNA 441Q  
2182-01189

1FR FR. CLEARED 5000 NY 125-7  
close to 5000 11200ND SALL FUEL FLOW 6076 APR 58 GPH  
4 F PROBABLY DATA TO 0.7 PSI - ENGINE RUNNING FINE  
TOLD NY DEPARTURE WE WERE TO RET FRG 9 BOUND  
TO RETAIN ALTITUDE TILL LAST CHANGE - <sup>ANALYST</sup> <sup>WRECKING</sup>  
NY DEP TURNED US 180 S. TOWARD FRG  
~~W/INTENT TO RET 4 CLEARED 20. TO 3000.~~

WE REINTERVIEWED 5000 TO WITHIN 1000' CLOSE TO FRG  
& STARTED DESCENT -

WE WERE RELEASED TO PROCEED. ~~FR 2000 TILL~~  
~~APPROX 10000. THEN 3000 SALLER 10000 4~~  
~~TURNED RT BASE 52. DECLARED EMERGENCY 4~~

~~ASKED TOWER P. TOWER CLEARED US TO LAND 32 #2~~  
~~BEHIND CHECKER ON 2nd FINAL - <sup>EMERGENCY</sup> ~~CHIEF OF POLICE~~ ~~WRECKING~~~~

SALLER SALLER & DECLARED EMERGENCY - ASKED  
TOWER TO PULL EQUIPMENT - GAVE FUEL & SALLER  
1RT TO CATCH INQUIRY. TOLD THEM WE WERE  
SHUTTING DOWN ALL DEVICES DUE TO SALLER -

@ FR 1400 SAW FLAMES FROM BOBBY RIDER POINTS  
TURNED ON SET TO CATCH GEAR & FLAMES -

EXCEEDED LAC RLY 32 TURNED OFF A5 &  
LEAVE'D AIRCRAFT. REMOVED SELF & PAX TO SAFE

DISTANCE. FRG FIRE TOWER #2 - EXTINGUISHING  
FLAMES -

[REDACTED]  
[REDACTED]

[REDACTED]