

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

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

**BASIC INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                                                                        |                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Accident/Incident Location</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                        | <b>Date/Time</b>                                                                                       |                                         |
| Nearest City/Place: <u>Hartford</u>                                                                                                                                                                                                                                                                                                                                                                                                            | State: <u>AL</u>       | Date: <u>09-19-2015</u><br><small>mm/dd/yyyy</small>                                                   | Local Time: <u>0915</u>                 |
| ZIP: <u>36344</u>                                                                                                                                                                                                                                                                                                                                                                                                                              | Country: <u>Geneva</u> | Time Zone: <u>1515</u>                                                                                 |                                         |
| Latitude: _____ (dd:mm:ss N/S) Longitude: _____ (ddd:mm:ss E/W)                                                                                                                                                                                                                                                                                                                                                                                |                        |                                                                                                        |                                         |
| <b>Phase of Operation</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                        | <b>Collision with Other Aircraft</b>                                                                   | <b>Altitude of In-Flight Occurrence</b> |
| <input type="checkbox"/> Standing <input checked="" type="checkbox"/> Takeoff (incl. initial climb) <input type="checkbox"/> Cruise <input type="checkbox"/> Hover<br><input type="checkbox"/> Taxi <input type="checkbox"/> Climb <input type="checkbox"/> Maneuvering <input type="checkbox"/> Other<br><input type="checkbox"/> Descent <input type="checkbox"/> Landing <input type="checkbox"/> Approach <input type="checkbox"/> Unknown |                        | <input type="checkbox"/> Midair<br><input type="checkbox"/> On-ground<br><input type="checkbox"/> None | <u>2'</u> ft MSL                        |

**AIRCRAFT INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Manufacturer:</b> <u>Hughes</u>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Max Gross Weight:</b> <u>1670</u> lbs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Model:</b> <u>Hughes 269B</u>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Weight at Time of Accident/Incident:</b> <u>1617</u> lbs                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Serial Number:</b> <u>67-0318</u>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Location of Center of Gravity at Time of Accident/Incident:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Registration Number:</b> <u>N141LL</u> Amateur-built: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>97.8</u> inches from <input type="checkbox"/> nose or <input checked="" type="checkbox"/> datum<br>-or- _____ Percent Mean Aerodynamic Cord (% MAC)                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Category of Aircraft</b>                                                                                                                                                                                                                                                                                                                                      | <b>Type of Airworthiness Certificate</b><br><small>(Check all that apply)</small>                                                                                                                                                                                                                                                                                                                                                                  | <b>Number of Seats:</b> _____<br>If Large Aircraft, how many seats for:                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <input 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 checked="" type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered lift<br><input type="checkbox"/> Ultralight<br><input type="checkbox"/> Unknown | <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><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 | Flight Crew: _____<br>Cabin Crew: _____<br>Passengers: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Landing Gear</b> <input type="checkbox"/> Retractable<br>Check any additional landing gear configuration that applies:<br><input 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 checked="" 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>04-16-2015</u><br><small>mm/dd/yyyy</small>                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                               | <b>Airframe Total Time:</b> <u>5092</u> hrs<br>hours measured at (check one)<br><input type="checkbox"/> Last Inspection <input checked="" type="checkbox"/> Time of Accident/Incident |
| <b>IFR Equipped</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                             | <b>Stall Warning System Installed</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                                 | <b>Type of Fire Extinguishing System</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Specify _____                                                         |
| <b>ELT Installed</b> <b>ELT Activated</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                    | <b>ELT Manufacturer:</b> _____                                                                                                                                                                                                                                                                |                                                                                                                                                                                        |
| <b>ELT Aided in Locating Accident/Incident</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                               | <b>Model/Series:</b> _____                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                               | <b>Serial Number:</b> _____                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                               | <b>Battery Type:</b> _____ <b>Battery Exp. Date:</b> _____                                                                                                                             |

|                                                                                                                                                                                                                                                               |                                                                                                                                   |                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <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 type="checkbox"/> Carburetor<br><input checked="" type="checkbox"/> Fuel Injected | <b>Propeller</b><br><input type="checkbox"/> Fixed Pitch <input type="checkbox"/> Controllable Pitch<br>Manufacturer: _____<br>Model: _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|

| 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>14IO-360-A1A</u> | <u>L-13964-S1A</u>           |                                           | <u>180</u>                                                                                                                             | <u>1596.4</u>      |                               |                             |
| Eng. 2 |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |
| Eng. 3 |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |
| Eng. 4 |                     |                     |                              |                                           |                                                                                                                                        |                    |                               |                             |

| OWNER/OPERATOR INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Registered Aircraft Owner</b><br>Name: _____<br>Fractional Ownership Aircraft: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Owner Address</b><br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                            |
| <b>Operator of Aircraft</b> <input type="checkbox"/> Same As Registered Owner<br>Name: <u>Eagle Aviation Academy</u><br>Doing Business As: _____<br>Air Carrier/Operator Designator (4 Character Code): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Operator Address</b> <input type="checkbox"/> Same As Registered Owner<br>City: <u>Ozark</u><br>State: <u>AL</u> ZIP: <u>36360</u><br>Country: <u>Dele U.S.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                            |
| <b>Regulation Flight Conducted Under</b><br><input checked="" type="checkbox"/> FAR 91 <input type="checkbox"/> FAR 129 <input type="checkbox"/> FAR 91 Special Flight <input type="checkbox"/> Public Use (select type)<br><input type="checkbox"/> FAR 103 <input type="checkbox"/> FAR 133 <input type="checkbox"/> Non-US, Commercial <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local<br><input type="checkbox"/> FAR 121 <input type="checkbox"/> FAR 135 <input type="checkbox"/> Non-US, Non-commercial <input type="checkbox"/> Unknown<br><input type="checkbox"/> FAR 125 <input type="checkbox"/> FAR 137 <input type="checkbox"/> Armed Forces |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Revenue Sightseeing Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Air Medical Flight</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |
| <b>Purpose of Flight</b><br>for FAR 91, 103, 133, 137 (Select one)<br><input checked="" type="checkbox"/> Personal<br><input type="checkbox"/> Business<br><input type="checkbox"/> Executive/Corporate<br><input type="checkbox"/> Other Work Use<br><input type="checkbox"/> Instructional<br><input type="checkbox"/> Ferry<br><input type="checkbox"/> Positioning<br><input type="checkbox"/> Aerial Application<br><input type="checkbox"/> Aerial Observation<br><input type="checkbox"/> Air Drop<br><input type="checkbox"/> Air Race / Show<br><input type="checkbox"/> Flight Test<br><input type="checkbox"/> Public Use<br><input type="checkbox"/> Unknown                                  | <b>Revenue Operation</b><br>for FAR 121, 125, 129, 135 (Select one)<br><input type="checkbox"/> Scheduled or Commuter<br><input type="checkbox"/> Non-Scheduled or Air Taxi<br><br><b>Domestic or International</b><br><input type="checkbox"/> Domestic <input type="checkbox"/> International<br><br><b>Cargo Operation</b><br><input type="checkbox"/> Passenger/Cargo<br><input type="checkbox"/> Passenger _____ How many?<br><input type="checkbox"/> Cargo _____ lbs<br><input type="checkbox"/> Mail | <b>Type of Commercial Operating Certificate Held</b><br>(Select all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (129)<br><input type="checkbox"/> Commuter Air Carrier (135)<br><input type="checkbox"/> On-Demand Air Taxi (135)<br><input type="checkbox"/> Large Helicopter (127)<br><input type="checkbox"/> Rotorcraft External Load (133)<br>- or -<br><input type="checkbox"/> Agricultural Aircraft (137)<br><input type="checkbox"/> Other Operator of Large Aircraft |                                                                                                                                                                            |
| OTHER AIRCRAFT – COLLISION (If air or ground collision occurred, complete this section for other aircraft)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
| <b>Aircraft Registration Number</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Manufacturer:</b> _____<br><b>Model:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Damage to Other Aircraft</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None |
| <b>Registered Owner of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
| <b>Pilot of Other Aircraft</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
| MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
| <b>Was there Mechanical Malfunction/Failure?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)<br><br><br><br>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Total Time/Cycles On Part</b><br>_____<br>Hours<br>_____<br>Cycles<br><br><b>Time Since This Part Inspected/Overhauled</b><br>_____<br>Hours                            |
| DAMAGE TO AIRCRAFT AND OTHER PROPERTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                            |
| <b>Aircraft Damage</b><br><input type="checkbox"/> None <input checked="" type="checkbox"/> Substantial<br><input type="checkbox"/> Minor <input type="checkbox"/> Destroyed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Aircraft Fire</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                      | <b>Aircraft Explosion</b><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Both Ground and In-Flight<br><input type="checkbox"/> In-Flight <input type="checkbox"/> Unknown Origin<br><input type="checkbox"/> On-Ground                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                            |

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

Main Rotor blade contact, T/R blade contact, tail boom separation, main mast separation, Landing gear collapses, plexiglass canopy damage.

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

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

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

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

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

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

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

**Approach Segment** (Select one)

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

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

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

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

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

**Runway Information**

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

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

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

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

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

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

 Airport ID: 54J

 City: Defunick

 State: FL

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

**Time of Departure**

 Time: 8:45 AM

 Time Zone: Central

\_\_\_\_\_

\_\_\_\_\_

**Destination**

Airport ID: \_\_\_\_\_

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

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

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

**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 ☐ Demo 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 & SERVICES INFORMATION**
**Fuel on Board at Last Takeoff**

(convert from pounds, as necessary)

22 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**

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

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

Pilot and passenger exited aircraft thru doors on each side of AC

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

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

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

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

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

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

**Source of Weather Information**

(Check all that apply)

- |                                                             |                                   |
|-------------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> National Weather Service           | <input type="checkbox"/> Company  |
| <input type="checkbox"/> Flight Service Station             | <input type="checkbox"/> Military |
| <input type="checkbox"/> TV/Radio                           | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Automated Report                   | <input type="checkbox"/> Unknown  |
| <input type="checkbox"/> Commercial Weather Service (DUATS) |                                   |

**Method of Briefing**

(Check all that apply)

- |                                             |
|---------------------------------------------|
| <input type="checkbox"/> In Person          |
| <input type="checkbox"/> Teletype           |
| <input type="checkbox"/> Telephone/Computer |
| <input type="checkbox"/> Aircraft Radio     |
| <input type="checkbox"/> TV/Radio           |
| <input type="checkbox"/> Unknown            |

**Briefing Type/Completeness**

- |                                                       |                                        |
|-------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Full                         | <input type="checkbox"/> Abbreviated   |
| <input type="checkbox"/> Partial / Limited By Pilot   | <input type="checkbox"/> Unknown       |
| <input type="checkbox"/> Partial / Limited By Briefer | <input type="checkbox"/> Not Pertinent |

**Light Condition**

- |                               |                                |                                       |
|-------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Dawn | <input type="checkbox"/> Dusk  | <input type="checkbox"/> Dark Night   |
| <input type="checkbox"/> Day  | <input type="checkbox"/> Night | <input type="checkbox"/> Bright Night |
|                               |                                | <input type="checkbox"/> Not Reported |

**Visibility**

\_\_\_\_\_ miles

**Sky/Lowest Cloud Condition**

- |                                              |                                        |
|----------------------------------------------|----------------------------------------|
| <input checked="" type="checkbox"/> Clear    | <input type="checkbox"/> Thin Broken   |
| <input type="checkbox"/> Few                 | <input type="checkbox"/> Thin Overcast |
| <input type="checkbox"/> Partial Obscuration | <input type="checkbox"/> Unknown       |
| <input type="checkbox"/> Scattered           |                                        |

**Ceiling**

- |                                                  |                                     |
|--------------------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> None (clear) | <input type="checkbox"/> Obscured   |
| <input type="checkbox"/> Broken                  | <input type="checkbox"/> Indefinite |
| <input type="checkbox"/> Overcast                | <input type="checkbox"/> Unknown    |

**Restriction to Visibility (Check all that apply)**

- |                                          |                                     |
|------------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Fog        |
| <input type="checkbox"/> Blowing Dust    | <input type="checkbox"/> Ground Fog |
| <input type="checkbox"/> Blowing Sand    | <input type="checkbox"/> Haze       |
| <input type="checkbox"/> Blowing Snow    | <input type="checkbox"/> Ice Fog    |
| <input type="checkbox"/> Blowing Spray   | <input type="checkbox"/> Smoke      |
| <input type="checkbox"/> Dust            | <input type="checkbox"/> Unknown    |

**Lowest Cloud Condition Height**

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

**Ceiling Height**

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

**Wind Direction**☐ Indicated:  
270 degrees MAG☐ Variable**Wind Speed**

Velocity: 10 KTS

-or-

- |                                             |
|---------------------------------------------|
| <input type="checkbox"/> Calm               |
| <input type="checkbox"/> Light and Variable |

**Wind Gusts**

Velocity: 10 KTS

- |                                                 |
|-------------------------------------------------|
| <input type="checkbox"/> Gusting                |
| <input checked="" type="checkbox"/> Not Gusting |

**Type of Turbulence (Check all that apply)**

- |                                          |                                                   |
|------------------------------------------|---------------------------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> In Clouds                |
| <input type="checkbox"/> Clear Air       | <input type="checkbox"/> Vicinity of Thunderstorm |

**Severity of Turbulence**

- |                                  |                                        |                                |
|----------------------------------|----------------------------------------|--------------------------------|
| <input type="checkbox"/> Extreme | <input type="checkbox"/> Moderate      | <input type="checkbox"/> Light |
| <input type="checkbox"/> Severe  | <input type="checkbox"/> Moderate Chop |                                |

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

Temperature: \_\_\_\_\_ (C)  
or \_\_\_\_\_ (F)Altimeter Setting: \_\_\_\_\_ in. HG  
or \_\_\_\_\_ MB

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

Dew Point: \_\_\_\_\_ (C)  
or \_\_\_\_\_ (F)**Icing Forecast****Amount**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Trace | <input type="checkbox"/> Severe   |
| <input type="checkbox"/> Light |                                   |

**Type**

- |                                |
|--------------------------------|
| <input type="checkbox"/> Rime  |
| <input type="checkbox"/> Clear |
| <input type="checkbox"/> Mixed |

**Icing Actual****Amount**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Trace | <input type="checkbox"/> Severe   |
| <input type="checkbox"/> Light |                                   |

**Type**

- |                                |
|--------------------------------|
| <input type="checkbox"/> Rime  |
| <input type="checkbox"/> Clear |
| <input type="checkbox"/> Mixed |

**Type of Precipitation (Check all that apply)**

- |                                        |                                             |
|----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> None          | <input type="checkbox"/> Drizzle            |
| <input type="checkbox"/> Rain          | <input type="checkbox"/> Ice Pellets        |
| <input type="checkbox"/> Snow          | <input type="checkbox"/> Snow Pellets       |
| <input type="checkbox"/> Hail          | <input type="checkbox"/> Snow Grains        |
| <input type="checkbox"/> Rain Showers  | <input type="checkbox"/> Ice Crystals       |
| <input type="checkbox"/> Freezing Rain | <input type="checkbox"/> Ice Pellets Shower |
| <input type="checkbox"/> Snow Shower   | <input type="checkbox"/> Freezing Drizzle   |

**Intensity of Precipitation**

- |                                |                                   |                                |
|--------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
|--------------------------------|-----------------------------------|--------------------------------|

# **PILOT "A" INFORMATION**

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

☒ Pilot
 ☐ Co-Pilot
 ☐ Student Pilot
 ☐ Flight Instructor
 ☐ Check Pilot
 ☐ Flight Engineer
 ☐ Other Flight Crew

## **Pilot "A" Identification**

First Name: Timothy Scott Miner  
 Middle Initial: S  
 Last Name: Miner

City: Hartford  
 State: AL ZIP: 36344  
 Country: U.S.

Age at time of Accident/Incident: 50 Date of Birth: [REDACTED] Certificate Number: [REDACTED]

## **Degree of Injury**

☐ None
 ☐ Fatal  
☒ Minor
 ☐ Unknown  
☐ Serious

## **Seat Occupied**

☒ Left
 ☐ Front
 ☐ Unknown  
☐ Right
 ☐ Rear  
☐ Center
 ☐ Single

## **Seat Belt**

Used ☒ Yes ☐ No  
 Available ☐ Yes ☐ No

## **Shoulder Harness**

Used ☒ Yes ☐ No  
 Available ☐ Yes ☐ No

## **Pilot Certificate(s) (Check all that apply)**

☐ None
 ☐ Student
 ☐ Recreational
 ☒ Commercial
 ☐ Flight Engineer
 ☐ Foreign  
☐ Private
 ☒ Flight Instructor
 ☐ Sport
 ☐ Airline Transport
 ☐ U.S. Military

## **Principal Occupation**

☒ Pilot  
☐ Other  
☐ Unknown

## **Medical Certificate**

☐ None
 ☐ Class 3  
☐ Class 1
 ☐ Driver's License (Sport Pilot only)  
☒ Class 2
 ☐ Unknown

## **Medical Certificate Validity**

☐ Without limitations/waivers  
☒ With limitations/waivers  
☐ Unknown

## **Date of Last Medical**

06/30/2015  
 mm/dd/yyyy

## **Medical Certificate Limitations**

Must have available glasses for new vision

## **Medical Certificate Waivers**

## **Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:**

03/23/2015  
 mm/dd/yyyy

## **Flight Review Aircraft**

Make: Bell  
 Model: 206BIII

## **Airplane Rating(s) (Check all that apply)**

☐ None  
☒ Single-Engine Land  
☐ Single-Engine Sea  
☐ Multiengine Land  
☐ Multiengine Sea

## **Other Aircraft Rating(s) (Check all that apply)**

☐ None  
☐ Airship  
☐ Free Balloon  
☐ Glider  
☐ Gyroplane  
☒ Helicopter  
☐ Powered Lift

## **Instrument Rating(s) (Check all that apply)**

☐ None  
☒ Airplane  
☒ Helicopter  
☐ Powered Lift

## **Instructor Rating(s) (Check all that apply)**

☐ None  
☒ Airplane Single-Engine  
☐ Airplane Multi-Engine  
☐ Gyroplane  
☐ Powered Lift  
☒ Instrument Airplane  
☒ Instrument Helicopter  
☒ Helicopter  
☐ Glider  
☐ Sport

## **Type Ratings**

## **Student Endorsements (Include dates)**

| 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                                                  | 5154         | 160               | 1200                   | 44                   | 1324  | 24.9       | 130       | 3912       |        |                  |
| Pilot in Command (PIC)                                      | 4856         |                   |                        |                      |       |            |           |            |        |                  |
| Time as Instructor                                          | 2649         |                   | 632                    | -                    |       |            |           | 2017       |        |                  |
| This Make/Model                                             |              |                   |                        |                      |       |            |           |            |        |                  |
| Last 90 Days                                                | 214          |                   |                        |                      |       |            |           |            |        |                  |
| Last 30 Days                                                |              |                   |                        |                      |       |            |           |            |        |                  |
| Last 24 Hours                                               |              |                   |                        |                      |       |            |           |            |        |                  |

**PILOT "B" INFORMATION****Pilot "B" Responsibilities at the Time of Accident/Incident**

☐ Pilot ☐ Co-Pilot ☐ Student Pilot ☐ Flight Instructor ☐ Check Pilot ☐ Flight Engineer ☐ Other Flight Crew

**Pilot "B" Identification**

First Name: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_

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

Age at time of Accident/Incident: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ mm/dd/yyyy Certificate Number: \_\_\_\_\_

**Degree of Injury**

☐ None ☐ Fatal  
☐ Minor ☐ Unknown  
☐ Serious

**Seat Occupied**

☐ Left ☐ Front ☐ Unknown  
☐ Right ☐ Rear  
☐ Center ☐ Single

**Seat Belt**

Used ☐ Yes ☐ No  
Available ☐ Yes ☐ No

**Shoulder Harness**

Used ☐ Yes ☐ No  
Available ☐ Yes ☐ No

**Pilot Certificate(s)** (Check all that apply)

☐ None ☐ Student ☐ Recreational ☐ Commercial ☐ Flight Engineer ☐ Foreign  
☐ Private ☐ Flight Instructor ☐ Sport ☐ Airline Transport ☐ U.S. Military

**Principal Occupation**

☐ Pilot  
☐ Other  
☐ Unknown

**Medical Certificate**

☐ None ☐ Class 3  
☐ Class 1 ☐ Driver's License (Sport Pilot only)  
☐ Class 2 ☐ Unknown

**Medical Certificate Validity**

☐ Without limitations/waivers  
☐ With limitations/waivers  
☐ Unknown

**Date of Last Medical**

\_\_\_\_\_  
mm/dd/yyyy

**Medical Certificate Limitations****Medical Certificate Waivers****Date of Last Flight Review  
or Equivalent, Including  
FAR 121/135 Checks:**

\_\_\_\_\_  
mm/dd/yyyy

**Flight Review Aircraft**

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

**Airplane Rating(s)**  
(Check all that apply)

☐ None  
☐ Single-Engine Land  
☐ Single-Engine Sea  
☐ Multiengine Land  
☐ Multiengine Sea

**Other Aircraft Rating(s)**  
(Check all that apply)

☐ None  
☐ Airship  
☐ Free Balloon  
☐ Glider  
☐ Gyroplane  
☐ Helicopter  
☐ Powered Lift

**Instrument Rating(s)**  
(Check all that apply)

☐ None  
☐ Airplane  
☐ Helicopter  
☐ Powered Lift

**Instructor Rating(s)**  
(Check all that apply)

☐ None ☐ Instrument Airplane  
☐ Airplane Single-Engine ☐ Instrument Helicopter  
☐ Airplane Multi-Engine ☐ Helicopter  
☐ Gyroplane ☐ Glider  
☐ Powered Lift ☐ Sport

**Type Ratings****Student Endorsements** (Include dates)**Flight Time** (enter appropriate  
number of hours in each box)

| All<br>Aircraft        | This Make<br>& Model | Airplane<br>Single<br>Engine | Airplane<br>Multiengine | Night | Instrument |           | Rotorcraft | Glider | Lighter<br>Than Air |
|------------------------|----------------------|------------------------------|-------------------------|-------|------------|-----------|------------|--------|---------------------|
|                        |                      |                              |                         |       | Actual     | Simulated |            |        |                     |
| Total Time             |                      |                              |                         |       |            |           |            |        |                     |
| Pilot in Command (PIC) |                      |                              |                         |       |            |           |            |        |                     |
| Time as Instructor     |                      |                              |                         |       |            |           |            |        |                     |
| This Make/Model        |                      |                              |                         |       |            |           |            |        |                     |
| Last 90 Days           |                      |                              |                         |       |            |           |            |        |                     |
| Last 30 Days           |                      |                              |                         |       |            |           |            |        |                     |
| Last 24 Hours          |                      |                              |                         |       |            |           |            |        |                     |

| ADDITIONAL FLIGHT CREW MEMBERS (Exclusive of cabin attendants, complete the following information)                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| <b>Pilot Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <b>Degree of Injury</b>                                                                                                                                                                                                             |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> None <input type="checkbox"/> Fatal                                                                                                                                                                        |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> Minor <input type="checkbox"/> Unknown                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  | <input type="checkbox"/> Serious                                                                                                                                                                                                    |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Pilot Certificate(s)</b> (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  | <b>Seat Occupied</b>                                                                                                                                                                                                                |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                            |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                           |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Pilot Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <b>Degree of Injury</b>                                                                                                                                                                                                             |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> None <input type="checkbox"/> Fatal                                                                                                                                                                        |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> Minor <input type="checkbox"/> Unknown                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  | <input type="checkbox"/> Serious                                                                                                                                                                                                    |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Pilot Certificate(s)</b> (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  | <b>Seat Occupied</b>                                                                                                                                                                                                                |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                            |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                           |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Pilot Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <b>Degree of Injury</b>                                                                                                                                                                                                             |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> None <input type="checkbox"/> Fatal                                                                                                                                                                        |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | <input type="checkbox"/> Minor <input type="checkbox"/> Unknown                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  | <input type="checkbox"/> Serious                                                                                                                                                                                                    |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Pilot Certificate(s)</b> (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  | <b>Seat Occupied</b>                                                                                                                                                                                                                |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military |  |  |  |  |  | <input type="checkbox"/> Left <input type="checkbox"/> Front<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single<br><input type="checkbox"/> Unknown |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                            |  |  |  |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                                                                                                           |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>PASSENGER(S) / OTHER PERSONNEL (Include flight attendants; continue on separate sheet if necessary)</b>                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| <b>Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  | <b>Seat</b>                                                                                                                                                                                                                         | <b>Crew</b>              | <b>Non-Revenue</b>                  | <b>Revenue</b>           | <b>Non-Occupant</b>      | <b>FAA</b>               | <b>Fatal</b>             | <b>Serious Injury</b>    | <b>Minor Injury</b>      | <b>No Injury</b>         | <b>Unknown</b>                      |
| First Name: _____ City: <u>Hartford</u>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  | L                                                                                                                                                                                                                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Middle Initial: _____ State: <u>AL</u> ZIP: <u>36344</u>                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: <u>U.S.</u>                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| First Name: _____ City: _____                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Middle Initial: _____ State: _____ ZIP: _____                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |
| Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |                                                                                                                                                                                                                                     |                          |                                     |                          |                          |                          |                          |                          |                          |                          |                                     |

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

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

Landed in field at father-in-laws farm to give wife a ride.

upon take off, applied collective to clear driveway  
sudden pitch down of nose, applied full aft cyclic.

Tail Rotor made ground contact, we landed on opposite side  
of driveway upright. I shut engine down by pulling mixture  
and turning battery off we exited aircraft and accessed  
damage and injuries

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

Operator/Owner Safety Recommendation

Walk landing area to see better all prospective hazards

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

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

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

|                                                                       |                                                                                                                        |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Date of this Report</b><br>09/29/2015<br><small>mm/dd/yyyy</small> | <b>Signature and Name of Pilot/Operator</b><br>Signature: [Redacted]<br>Type or Print Name: <u>Timothy Scott Miner</u> |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|

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

Signature: \_\_\_\_\_  
Type or Print Name: \_\_\_\_\_  
Title: \_\_\_\_\_

**FOR NTSB USE ONLY**

|                                                 |                                                        |                                           |                                        |
|-------------------------------------------------|--------------------------------------------------------|-------------------------------------------|----------------------------------------|
| <b>NTSB Accident/Incident No.</b><br>ERA15CA364 | <b>Reviewed by NTSB Regional Office</b><br>ASHBURN, VA | <b>Name of Investigator</b><br>L. SCHIADA | <b>Date Report Received</b><br>10/1/15 |
|-------------------------------------------------|--------------------------------------------------------|-------------------------------------------|----------------------------------------|