

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

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

## BASIC INFORMATION

|                                                                                                                                                                                                                                              |  |                                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|
| Accident/Incident Location<br>Nearest City/Place: <u>Red Lion</u> State: <u>PA</u><br>ZIP: <u>17356</u> Country: <u>USA</u><br>Latitude: <u>39.94°N</u> Longitude: <u>76.58°W</u><br>(Enter in decimal degrees or degrees: minutes: seconds) |  | Accident/Incident Date/Time<br>Date: <u>04-11-2017</u> Local Time: <u>10:30 AM</u><br>mm/dd/yyyy Time Zone: <u>Eastern</u>        |  |
|                                                                                                                                                                                                                                              |  | Collision with Other Aircraft: <input type="radio"/> Midair <input type="radio"/> On-ground <input checked="" type="radio"/> None |  |

## AIRCRAFT INFORMATION

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Registration Number: <u>N3846T</u><br>Manufacturer: <u>ZENITH LAZEAR, JOHN</u><br>Model: <u>STOL CH 701</u><br>Serial Number: <u>73696</u><br>Year of Manufacture: <u>2000</u><br>Amateur-Built: <input checked="" type="radio"/> Yes <input type="radio"/> No If Yes: <input checked="" type="radio"/> Kit/Plans <input type="radio"/> Original Design Make: <u>ZENITH</u> |  | <input type="checkbox"/> IFR-Equipped and Certified<br><input type="checkbox"/> Commercial Space Flight<br><input type="checkbox"/> Unmanned Aircraft<br>Maximum Gross Weight: <u>960</u> lbs<br>Weight at Time of Accident/Incident: <u>750</u> lbs<br>Number of Seats: <u>2</u> Flight Crew Seats: <u>1</u><br>Cabin Crew Seats: <u>0</u> Passenger Seats: <u>1</u><br>Number of Engines: <u>1</u> |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

| Category of Aircraft<br><input checked="" type="radio"/> Airplane<br><input type="radio"/> Balloon<br><input type="radio"/> Blimp/Dirigible<br><input type="radio"/> Glider<br><input type="radio"/> Gyroplane<br><input type="radio"/> Helicopter<br><input type="radio"/> Powered Lift<br><input type="radio"/> Rocket<br><input type="radio"/> Ultralight<br><input type="radio"/> Unknown | Type of Airworthiness Certificate<br>(Check all that apply)<br><table style="width: 100%;"> <tr> <th>Standard</th> <th>Special</th> </tr> <tr> <td> <input type="checkbox"/> Normal<br/> <input type="checkbox"/> Aerobatic<br/> <input type="checkbox"/> Balloon<br/> <input type="checkbox"/> Commuter<br/> <input type="checkbox"/> Transport<br/> <input type="checkbox"/> Utility               </td> <td> <input type="checkbox"/> Restricted<br/> <input type="checkbox"/> Limited<br/> <input type="checkbox"/> Provisional<br/> <input type="checkbox"/> Special Flight<br/> <input checked="" type="checkbox"/> Experimental<br/> <input type="checkbox"/> Special Light-Sport<br/> <input type="checkbox"/> Experimental Light-Sport               </td> </tr> </table> <input type="checkbox"/> Certificate of Authorization or Waiver (COA)<br><input type="checkbox"/> None <input type="checkbox"/> Unknown | Standard | Special | <input type="checkbox"/> Normal<br><input type="checkbox"/> Aerobatic<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Commuter<br><input type="checkbox"/> Transport<br><input type="checkbox"/> Utility | <input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Special Flight<br><input checked="" type="checkbox"/> Experimental<br><input type="checkbox"/> Special Light-Sport<br><input type="checkbox"/> Experimental Light-Sport | Landing Gear<br>(Check all that apply)<br><input type="checkbox"/> Retractable<br><input checked="" type="checkbox"/> Tricycle<br><input type="checkbox"/> Amphibian<br><input type="checkbox"/> Emergency Float<br><input type="checkbox"/> Float<br><input type="checkbox"/> Hull<br><input type="checkbox"/> Other Launch/Recovery System<br><input type="checkbox"/> None | Engine Type (Select one)<br><input checked="" type="radio"/> Reciprocating <input type="radio"/> Liquid Rocket<br><input type="radio"/> Turbo Shaft <input type="radio"/> Solid Rocket<br><input type="radio"/> Turbo Prop <input type="radio"/> Hybrid Rocket<br><input type="radio"/> Turbo Jet <input type="radio"/> None<br><input type="radio"/> Turbo Fan <input type="radio"/> Unknown<br><input type="radio"/> Electric<br>Fuel System Type (Reciprocating)<br><input checked="" type="radio"/> Carburetor <input type="radio"/> Fuel-Injected |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Standard                                                                                                                                                                                                                                                                                                                                                                                      | Special                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |         |                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> Normal<br><input type="checkbox"/> Aerobatic<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Commuter<br><input type="checkbox"/> Transport<br><input type="checkbox"/> Utility                                                                                                                                                                      | <input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Special Flight<br><input checked="" type="checkbox"/> Experimental<br><input type="checkbox"/> Special Light-Sport<br><input type="checkbox"/> Experimental Light-Sport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          |         |                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg. mm/dd/yyyy | Rated Power<br><input checked="" type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time (hours) | Time Since Inspection (hours) | Time Since Overhaul (hours) |
|--------|---------------------|---------------------|------------------------------|-------------------------|------------------------------------------------------------------------------------------------------|--------------------|-------------------------------|-----------------------------|
| Eng. 1 | <u>ROTAX</u>        | <u>912 UL</u>       |                              | <u>2000</u>             | <u>80</u>                                                                                            | <u>469</u>         | <u>40</u>                     | <u>469</u>                  |
| Eng. 2 |                     |                     |                              |                         |                                                                                                      |                    |                               |                             |
| Eng. 3 |                     |                     |                              |                         |                                                                                                      |                    |                               |                             |
| Eng. 4 |                     |                     |                              |                         |                                                                                                      |                    |                               |                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Last Inspection Type<br><input type="radio"/> 100-Hour <input type="radio"/> Continuous Airworthiness<br><input type="radio"/> AAIP <input checked="" type="radio"/> Conditional Inspection<br><input type="radio"/> Annual <input type="radio"/> Unknown<br>Date Last Inspection: <u>10/31/2016</u><br>mm/dd/yyyy<br>Airframe Total Time: <u>469</u> hrs<br>hours measured at: (Select one)<br><input type="radio"/> Last Inspection <input checked="" type="radio"/> Time of Accident/Incident | Propeller 1<br><input type="radio"/> Fixed Pitch<br><input type="radio"/> Controllable Pitch<br><input checked="" type="radio"/> Ground Adjustable<br>Manufacturer: <u>WARP DRIVE</u><br>Model: _____<br>Propeller 2<br><input type="radio"/> Fixed Pitch<br><input checked="" type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br>Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Additional Equipment (Check all that apply)<br><input type="checkbox"/> ADS-B<br><input type="checkbox"/> Airframe Parachute<br><input type="checkbox"/> Angle of Attack Indicator<br><input type="checkbox"/> Autopilot<br><input type="checkbox"/> Data Recorder<br><input type="checkbox"/> Electronic Flight Bag or Handheld Device<br><input type="checkbox"/> Electronic Multifunction Display<br><input type="checkbox"/> Electronic Primary Flight Display<br><input type="checkbox"/> Handheld GPS<br><input type="checkbox"/> Heads Up Display<br><input type="checkbox"/> Onboard Weather<br><input type="checkbox"/> Satellite Tracking Device<br><input type="checkbox"/> Stall Warning System<br><input type="checkbox"/> Video Recording Device<br><input type="checkbox"/> Other, Specify: _____ |
| Type of Maintenance Program (Select one)<br><input type="radio"/> Annual<br><input type="radio"/> Conditional (Amateur-built only)<br><input type="radio"/> Manufacturer's Inspection Program<br><input type="radio"/> Other Approved Inspection Program (AAIP)<br><input type="radio"/> Continuous Airworthiness<br><input type="radio"/> Other, specify: _____                                                                                                                                 | ELT Installed: <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If Yes:<br>ELT Manufacturer: _____<br>Model or Part No.: _____<br>TSO No.: <input type="radio"/> C91 (121.5 MHz) <input type="radio"/> C91a (121.5 MHz)<br><input type="radio"/> C126 (406 MHz)<br>Was ELT still mounted in aircraft? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>Was ELT still connected to antenna? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>Did ELT Activate? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If activated:<br>Did ELT Aid in Locating Aircraft? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If not activated:<br>Indicate Reason: <input type="checkbox"/> Impact Damage<br><input type="checkbox"/> Fire Damage<br><input type="checkbox"/> Battery Expired/Damaged<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Description of Fire Extinguishing System<br><input type="radio"/> None<br><input type="radio"/> Specify: _____                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

**OWNER/OPERATOR INFORMATION**

Registered Aircraft Owner

Name: JOHN P. StoneCity: Red LionState: PA ZIP: 17356Fractional Ownership Aircraft: ☐ Yes ☒ NoCountry: USAOperator of Aircraft ☒ Same As Registered Owner☒ Same Address as Registered Owner

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

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

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

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

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

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

Operating Certificates Held  
(Check all that apply)

Regulation Flight Conducted Under

Revenue Operation for FAR 121, 125, 129, 135  
(Select one for each group)

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

- ☒ FAR 91 ☐ FAR 129 ☐ FAR 415  
☐ FAR 103 ☐ FAR 133 ☐ FAR 431  
☐ FAR 121 ☐ FAR 135 ☐ FAR 435  
☐ FAR 125 ☐ FAR 137 ☐ FAR 437  
  
☐ FAR 91 Special Flight  
☐ Non-US, Commercial  
☐ Non-US, Non-commercial

- ☐ Scheduled or Commuter ☐ Domestic  
☐ Non-Scheduled or Air Taxi ☐ International  
  
☐ Passenger ☒ N/A  
☐ Cargo  
☐ Mail Contract Only

Purpose of Flight for FAR 91, 103, 133, 137  
(Select one)

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

Revenue Sightseeing Flight

☐ Yes ☒ No

Air Medical Flight

☐ Yes ☒ No**AIRPORT INFORMATION** (Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)

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

Distance From Airport Center: \_\_\_\_\_ sm

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

Direction From Airport: \_\_\_\_\_ degrees true

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

Airport Elevation: \_\_\_\_\_ ft. msl

Runway Information

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

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

Runway/Landing Surface (Check all that apply)

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

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

Approach/Departure Segment (Select one)

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

IFR Approach (Check all that apply)

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

VFR Approach (Check all that apply)

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

# FLIGHT CREWMEMBER INFORMATION

Flight Crewmember Responsibilities at the Time of Accident/Incident

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

Flight Crewmember If was pilot flying ☒ Yes ☐ No

Flight Crewmember Identification

First Name: JOHN

City of Residence: Red Lion

Middle Initial: P.

State: PA ZIP: 17356

Last Name: Stone

Country: USA

Age at time of Accident/Incident: 42 Date of Birth: 1974 mm/dd/yyyy

Certificate Number: 1 [REDACTED]

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input checked="" type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                           |  | <b>Seat Occupied</b><br><input checked="" type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single              |  | <b>Restraint Type</b><br>\$ YUIUE<br><input type="radio"/> None <input type="radio"/> Used<br><input type="radio"/> Lap only <input type="radio"/> Lap only<br><input checked="" type="radio"/> 3-point <input type="radio"/> 3-point<br><input type="radio"/> 4-point <input type="radio"/> 4-point<br><input type="radio"/> 5-point <input type="radio"/> 5-point<br><input type="radio"/> Unknown <input type="radio"/> Unknown |  | <b>Restraint V</b><br><input checked="" type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input checked="" type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer |  |                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                 |  |
| <b>Principal Occupation</b><br><input checked="" type="radio"/> Pilot<br><input type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                |  | <b>Medical Certificate</b><br><input type="radio"/> None <input checked="" type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown |  | <b>Medical Certificate Validity</b><br><input checked="" type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                            |  | <b>Date of Last Medical</b><br><u>10-25-2016</u><br>mm/dd/yyyy                                                                                                                                                                  |  |

Medical Certificate Limitations  
None

Medical Certificate Special Issuance

|                                                                                                      |                                                                             |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks: <u>10/2015</u><br>mm/dd/yyyy | <b>Flight Review Aircraft</b><br>Make: <u>Piper</u><br>Model: <u>Seneca</u> |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Airplane Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input checked="" type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea | <b>Other Aircraft Rating(s)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift | <b>Instrument Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift | <b>Instructor Rating(s)</b><br>(Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                     |                                             |
|---------------------|---------------------------------------------|
| <b>Type Ratings</b> | <b>Student Endorsements</b> (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                                                  | 835          | 85                | 822                    | 13                   | 50    | 15         | 30        | 1.8        | 0      | 0                |
| Pilot in Command (PIC)                                      | 740          | 85                | 725                    | 13                   | 50    | 15         | 30        | 0          | 0      | 0                |
| Time as Instructor                                          | 0            | 0                 | 0                      | 0                    | 0     | 0          | 0         | 0          | 0      | 0                |
| This Make/Model                                             |              |                   |                        |                      |       |            |           |            |        |                  |
| Last 90 Days                                                | 70           | 19                | 70                     | 0                    | 0     | 0          | 0         | 0          | 0      | 0                |
| Last 30 Days                                                | 25           | 8                 | 25                     | 0                    | 0     | 0          | 0         | 0          | 0      | 0                |
| Last 24 Hours                                               | 2            | 2                 | 2                      | 0                    | 0     | 0          | 0         | 0          | 0      | 0                |

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

# FLIGHT ITINERARY INFORMATION

|                                                                                                                                             |  |                                                                                |  |                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Last Departure Point</b><br>Airport ID: <u>Home</u><br>City: <u>245 White Oak Rd</u><br>State: <u>Red Lion PA</u><br>Country: <u>USA</u> |  | <b>Time of Departure</b><br>Time: <u>10:30 AM</u><br>Time Zone: <u>Eastern</u> |  | <b>Destination</b><br>Airport ID: <u><del>KLWS</del> KLWS</u><br>City: <u>Lancaster</u><br>State: <u>PA</u><br>Country: <u>USA</u> |  | <b>Type Flight Plan Filed</b><br><input checked="" type="radio"/> None <input type="radio"/> VFR/IFR<br><input type="radio"/> Company VFR <input type="radio"/> IFR<br><input type="radio"/> Military VFR <input type="radio"/> Unknown<br><input type="radio"/> VFR<br>Activated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| <b>Type of ATC Clearance/Service</b> (Check all that apply)<br><input checked="" type="checkbox"/> None <input type="checkbox"/> Special VFR <input type="checkbox"/> Special IFR <input type="checkbox"/> VFR Flight Following <input type="checkbox"/> Cruise<br><input type="checkbox"/> VFR <input type="checkbox"/> IFR <input type="checkbox"/> VFR On Top <input type="checkbox"/> Traffic Advisory <input type="checkbox"/> Unknown / NA |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------|
| <b>Airspace where the accident/incident occurred</b> (Check all that apply)<br><input type="checkbox"/> Class A <input type="checkbox"/> Class G <input type="checkbox"/> Military Operations Area (MOA) <input type="checkbox"/> Special<br><input type="checkbox"/> Class B <input type="checkbox"/> Demo Area <input type="checkbox"/> Airport Advisory Area <input type="checkbox"/> Air Traffic Control Area<br><input type="checkbox"/> Class C <input type="checkbox"/> Warning Area <input type="checkbox"/> Jet Training Area <input checked="" type="checkbox"/> Unknown<br><input type="checkbox"/> Class D <input type="checkbox"/> Prohibited Area <input type="checkbox"/> TRSA<br><input type="checkbox"/> Class E <input type="checkbox"/> Restricted Area <input type="checkbox"/> FAR 93 |  |  | <b>Altitude of In-Flight Occurrence:</b><br><u>900</u> ft msl<br><u>Impact w/ ground</u> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------|

## WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE

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

|                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input type="radio"/> IMC <input type="radio"/> Night <input type="radio"/> Bright Night<br><input type="radio"/> Unknown                                                                                                     |  | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night |  |
| <b>Sky/Lowest Cloud Condition</b><br><input checked="" type="radio"/> Clear <input type="radio"/> Thin Broken <input type="radio"/> Obscured<br><input type="radio"/> Few <input type="radio"/> Thin Overcast <input type="radio"/> Indefinite<br><input type="radio"/> Partial Obscuration <input type="radio"/> Unknown <input type="radio"/> Unknown<br><input type="radio"/> Scattered |  | <b>Ceiling</b><br><input checked="" type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input type="radio"/> Unknown                       |  |
| <b>Lowest Cloud Condition Height</b><br>_____ ft agl                                                                                                                                                                                                                                                                                                                                       |  | <b>Ceiling Height</b><br>_____ ft agl                                                                                                                                                                                                                 |  |

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

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

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

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

None Applicable

**DAMAGE TO AIRCRAFT AND OTHER PROPERTY****Aircraft Damage**

- ☐ None      ☒ Substantial  
☐ Minor      ☐ Destroyed  
                 ☐ Unknown

**Aircraft Fire**

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

**Aircraft Explosion**

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

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

no property; Damage, nose gear folded back, propeller broken, left wing buckled, fus damage, main gear snapped

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

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

see email

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

Operator/Owner Safety Recommendation

Don't become overconfident in your plane,  
possible wind shear problem, This is what I think  
Happened

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

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

Total Time/Cycles  
On Part

\_\_\_\_\_ Hours

\_\_\_\_\_ Cycles

Time Since This Part  
Inspected/Overhauled

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**

Fuel on Board at Last Takeoff

(Convert from pounds, as necessary)

\_\_\_\_\_ 10 \_\_\_\_\_ Gallons

Fuel Type

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

Other Services, if Any, Prior to Departure

None

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

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

I walked out

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

Aircraft Registration Number

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

Damage to Other Aircraft

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

☐ Destroyed☐ Minor☐ Substantial☐ None

Registered Owner of Other Aircraft

Pilot of Other Aircraft

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

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

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

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

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

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

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

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

ADDITIONAL INFORMATION (Please type or print in ink)

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

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

|                                                                       |                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of this Report<br><u>04/12/2017</u><br><small>mm/dd/yyyy</small> | Name of Pilot/Operator: <u>John P. Stone</u><br>Signature: <br><small>-- or --</small> <input type="checkbox"/> Check here to electronically sign this document |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

If a Person Other than Pilot/Operator is Filing Report

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

| FOR NTSB USE ONLY                        |                                         |                                  |                      |
|------------------------------------------|-----------------------------------------|----------------------------------|----------------------|
| NTSB Accident/Incident No.<br>ERA17LA128 | Reviewed by NTSB Regional Office<br>ERA | Name of Investigator<br>D. Boggs | Date Report Received |