

**NATIONAL TRANSPORTATION SAFETY BOARD**  
**PILOT/OPERATOR AIRCRAFT ACCIDENT/INCIDENT REPORT**  
**This form to be used for reporting civil and public aircraft accidents and incidents**

**BASIC INFORMATION**

|                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                       |
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| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>Bayonne</u> State: <u>NJ</u><br>ZIP: _____ Country: _____<br>Latitude: _____ Longitude: _____<br><small>(Enter in decimal degrees or degrees:minutes:seconds)</small> | <b>Accident/Incident Date/Time</b><br>Date: <u>02/19/2017</u> Local Time: _____<br><small>mm/dd/yyyy</small><br>Time Zone: <u>ET</u><br><b>Collision with Other Aircraft:</b> <input type="radio"/> Midair <input type="radio"/> On-ground <input type="radio"/> None |
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**AIRCRAFT INFORMATION**

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <b>Registration Number:</b> <u>N15745</u><br><b>Manufacturer:</b> <u>PIPER</u><br><b>Model:</b> <u>ARROW</u><br><b>Serial Number:</b> _____<br><b>Year of Manufacture:</b> _____<br><b>Amateur-Built:</b> <input type="radio"/> Yes <input checked="" type="radio"/> No<br><small>If Yes: <input type="radio"/> Kit/Plans <input type="radio"/> Original Design Make: _____</small> | <input type="checkbox"/> IFR-Equipped and Certified<br><input type="checkbox"/> Commercial Space Flight<br><input type="checkbox"/> Unmanned Aircraft<br><b>Maximum Gross Weight:</b> _____ lbs<br><b>Weight at Time of Accident/Incident:</b> _____ lbs<br><b>Number of Seats:</b> <u>4</u> <b>Flight Crew Seats:</b> _____<br><b>Cabin Crew Seats:</b> _____ <b>Passenger Seats:</b> _____<br><b>Number of Engines:</b> <u>1</u> |
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| <b>Category of Aircraft</b><br><input checked="" type="radio"/> Airplane<br><input type="radio"/> Balloon<br><input type="radio"/> Blimp/Dirigible<br><input type="radio"/> Glider<br><input type="radio"/> Gyroplane<br><input type="radio"/> Helicopter<br><input type="radio"/> Powered Lift<br><input type="radio"/> Rocket<br><input type="radio"/> Ultralight<br><input type="radio"/> Unknown | <b>Type of Airworthiness Certificate</b><br><small>(Check all that apply)</small> <table style="width: 100%;"><tr><td style="width: 50%;"><b>Standard</b><br/><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 style="width: 50%;"><b>Special</b><br/><input type="checkbox"/> Restricted<br/><input type="checkbox"/> Limited<br/><input type="checkbox"/> Provisional<br/><input type="checkbox"/> Special Flight<br/><input 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 | <b>Standard</b><br><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 | <b>Special</b><br><input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Special Flight<br><input type="checkbox"/> Experimental<br><input type="checkbox"/> Special Light-Sport<br><input type="checkbox"/> Experimental Light-Sport | <b>Landing Gear</b><br><small>(Check all that apply)</small><br><input checked="" type="checkbox"/> Retractable<br><input checked="" type="checkbox"/> Tricycle <input type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Other Launch/Recovery System<br><input type="checkbox"/> None <input type="checkbox"/> Unknown | <b>Engine Type (Select one)</b><br><input checked="" type="radio"/> Reciprocating <input type="radio"/> Liquid Rocket<br><input type="radio"/> Turbo Shaft <input type="radio"/> Solid Rocket<br><input type="radio"/> Turbo Prop <input type="radio"/> Hybrid Rocket<br><input type="radio"/> Turbo Jet <input type="radio"/> None<br><input type="radio"/> Turbo Fan <input type="radio"/> Unknown<br><input type="radio"/> Electric<br><b>Fuel System Type (Reciprocating)</b><br><input type="radio"/> Carburetor <input checked="" type="radio"/> Fuel-Injected |
| <b>Standard</b><br><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                                                                                                                                                          | <b>Special</b><br><input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Special Flight<br><input 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.<br><small>mm/dd/yyyy</small> | Rated Power<br><input type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time<br>(hours) | Time Since:<br>Inspection<br>(hours) | Overhaul<br>(hours) |
|--------|---------------------|---------------------|------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------|
| Eng. 1 |                     |                     |                              |                                           |                                                                                           |                       |                                      |                     |
| Eng. 2 |                     |                     |                              |                                           |                                                                                           |                       |                                      |                     |
| Eng. 3 |                     |                     |                              |                                           |                                                                                           |                       |                                      |                     |
| Eng. 4 |                     |                     |                              |                                           |                                                                                           |                       |                                      |                     |

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| <b>Last Inspection Type</b><br><input type="radio"/> 100-Hour <input type="radio"/> Continuous Airworthiness<br><input type="radio"/> AAIP <input type="radio"/> Conditional Inspection<br><input type="radio"/> Annual <input type="radio"/> Unknown<br><b>Date Last Inspection:</b> _____<br><small>mm/dd/yyyy</small><br><b>Airframe Total Time:</b> _____ hrs<br><small>hours measured at (Select one)</small><br><input type="radio"/> Last Inspection <input type="radio"/> Time of Accident/Incident | <b>Propeller 1</b><br><input type="radio"/> Fixed Pitch<br><input checked="" type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br>Manufacturer: _____<br>Model: _____<br><b>Propeller 2</b><br><input type="radio"/> Fixed Pitch<br><input type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br>Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>ELT Installed:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br><small>If Yes:</small><br><b>ELT Manufacturer:</b> _____<br><b>Model or Part No.:</b> _____<br><b>TSO No.:</b> <input type="radio"/> C91 (121.5 MHz) <input type="radio"/> C91a (121.5 MHz)<br><input type="radio"/> C126 (406 MHz)<br><b>Was ELT still mounted in aircraft?</b> <input type="radio"/> Yes <input type="radio"/> No<br><b>Was ELT still connected to antenna?</b> <input type="radio"/> Yes <input type="radio"/> No<br><b>Did ELT Activate?</b> <input type="radio"/> Yes <input type="radio"/> No<br><small>If activated:</small><br><b>Did ELT Aid in Locating Aircraft:</b> <input type="radio"/> Yes <input type="radio"/> No<br><small>If not activated:</small><br><b>Indicate Reason:</b> <input type="checkbox"/> Impact Damage<br><input type="checkbox"/> Fire Damage<br><input type="checkbox"/> Battery Expired/Damaged<br><input type="checkbox"/> Unknown |
| <b>Type of Maintenance Program (Select one)</b><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: _____                                                                                                                                     | <b>Additional Equipment (Check all that apply)</b><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: _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Description of Fire Extinguishing System</b><br><input type="radio"/> None<br><input checked="" type="radio"/> Specify: <b>HANDHELD PORTABLE</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
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| "FLIGHT CREWMEMBER 1" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| "Flight Crewmember 1" Responsibilities at the Time of Accident/Incident<br><input checked="" type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| "Flight Crewmember 1" was pilot flying <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| "Flight Crewmember 1" Identification<br>First Name: <u>GEORGE</u> City of Residence: <u>WHEATLEY HEIGHTS</u><br>Middle Initial: _____   State: <u>NY</u> ZIP: <u>11798</u><br>Last Name: <u>PETTWAY</u> Country: <u>USA</u><br>Age at time of Accident/Incident: <u>56</u> Date of Birth: _____ mm/dd/yyyy<br>Certificate Number: _____                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Degree of Injury<br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input checked="" type="radio"/> Serious                                                                                                                                                                                                                                                                                           |              | Seat Occupied<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                                                                                      |                        | Restraint Type<br>Available   Used<br><input type="radio"/> None <input type="radio"/> None<br><input type="radio"/> Lap only <input type="radio"/> Lap only<br><input checked="" type="radio"/> 3-point <input checked="" 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 |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Inflatable Restraints<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 |                                                         |        |                  |
| Pilot Certificate(s) (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 |              | Medical Certificate<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                                                                         |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                | Medical Certificate Validity<br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input checked="" type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    | Date of Last Medical<br><u>07/13/2015</u><br>mm/dd/yyyy |        |                  |
| Medical Certificate Limitations<br>POSSESS READING GLASSES                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Medical Certificate Special Issuance                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks: _____ mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                              |                        | Flight Review Aircraft<br>Make: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Airplane Rating(s) (Check all that apply)<br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                   |              | Other Aircraft Rating(s) (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 |                        | Instrument Rating(s) (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                  | Instructor Rating(s) (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 |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Type Ratings                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  | Student Endorsements (Include dates)<br>Complex - see logbook.                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Flight Time (Enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                   | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                            | Airplane Single Engine | Airplane Multiengine                                                                                                                                                                                                                                                                                                                                                                                                                           | Night                                                                                                                                                                                                                                            | Instrument<br>Actual   Simulated                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                    | Rotorcraft                                              | Glider | Lighter Than Air |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                    |                                                         |        |                  |

“FLIGHT CREWMEMBER 2” INFORMATION

“Flight Crewmember 2” Responsibilities at the Time of Accident/Incident

☐ Pilot

☐ Co-Pilot

☐ Student Pilot

☐ Flight Instructor

☐ Check Pilot

☐ Flight Engineer

☐ Other Flight Crew

“Flight Crewmember 2” was pilot flying

☐ Yes

☐ No

“Flight Crewmember 2” Identification

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

City of Residence: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

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

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

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

Age at time of Accident/Incident: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ mm/dd/yyyy

Certificate Number: \_\_\_\_\_

Degree of Injury

☐ None

☐ Fatal

☐ Minor

☐ Unknown

☐ Serious

Seat Occupied

☐ Left

☐ Front

☐ Unknown

☐ Right

☐ Rear

☐ Center

☐ Single

Restraint Type

Available

☐ None

☐ Lap only

☐ 3-point

☐ 4-point

☐ 5-point

☐ Unknown

Used

☐ None

☐ Lap only

☐ 3-point

☐ 4-point

☐ 5-point

☐ Unknown

Inflatable Restraints

☐ Not Installed

☐ Installed

☐ Not Deployed

☐ Deployed

☐ Unknown

Pilot Certificate(s) (Check all that apply)

☐ None

☐ Private

☐ Student

☐ Flight Instructor

☐ Recreational

☐ Sport

☐ Commercial

☐ Airline Transport

☐ Flight Engineer

☐ US Military

☐ Foreign

Medical Certificate Validity

☐ Without limitations/waivers

☐ With limitations/waivers

☐ Special Issuance

☐ Unknown

☐ N/A

Date of Last Medical

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

Principal Occupation

☐ Pilot

☐ Other

☐ Unknown

Medical Certificate

☐ None

☐ Class 1

☐ Class 2

☐ Class 3

☐ Driver’s License (Sport Pilot only)

☐ Unknown

Medical Certificate Limitations

Medical Certificate Special Issuance

Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks: \_\_\_\_\_ mm/dd/yyyy

Flight Review Aircraft

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

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

Airplane Rating(s) (Check all that apply)

☐ None

☐ Single-Engine Land

☐ Single-Engine Sea

☐ Multiengine Land

☐ Multiengine Sea

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

☐ None

☐ Airship

☐ Balloon

☐ Glider

☐ Gyroplane

☐ Helicopter

☐ Powered Lift

Instrument Rating(s) (Check all that apply)

☐ None

☐ Airplane

☐ Helicopter

☐ Powered Lift

Instructor Rating(s) (Check all that apply)

☐ None

☐ Airplane Single-Engine

☐ Airplane Multi-Engine

☐ Gyroplane

☐ Powered Lift

☐ Instrument Airplane

☐ Instrument Helicopter

☐ Helicopter

☐ Glider

☐ Sport

Type Ratings

Student Endorsements (Include dates)

Flight Time (Enter appropriate number of hours in each box)

All Aircraft

This Make & Model

Airplane Single Engine

Airplane Multiengine

Night

Instrument

Actual

Simulated

Rotorcraft

Glider

Lighter Than Air

Total Time

Pilot in Command (PIC)

Time as Instructor

This Make/Model

Last 90 Days

Last 30 Days

Last 24 Hours

6

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

|                             |                          |                          |                                                                                                               |
|-----------------------------|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Last Departure Point</b> | <b>Time of Departure</b> | <b>Destination</b>       | <b>Type Flight Plan Filed</b>                                                                                 |
| Airport ID: <u>KFRG</u>     | Time: _____              | Airport ID: <u>KFRG</u>  | <input type="radio"/> None <input type="radio"/> VFR/IFR                                                      |
| City: <u>FARMINGDALE</u>    |                          | City: <u>FARMINGDALE</u> | <input type="radio"/> Company VFR <input type="radio"/> IFR                                                   |
| State: <u>NY</u>            | Time Zone: _____         | State: <u>NY</u>         | <input type="radio"/> Military VFR <input type="radio"/> Unknown                                              |
| Country: <u>USA</u>         |                          | Country: <u>USA</u>      | <input checked="" type="radio"/> VFR                                                                          |
|                             |                          |                          | <b>Activated?</b> <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Unknown |

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

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

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

| Basic Conditions                                                                                   | Light Condition                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown | <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 type="radio"/> Clear <input type="radio"/> Thin Broken<br><input type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input checked="" type="radio"/> Unknown<br><input type="radio"/> Scattered | <b>Ceiling</b><br><input type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input checked="" type="radio"/> Unknown | <b>Temperature:</b> _____ (C) or _____ (F)<br><b>Dew Point:</b> _____ (C) or _____ (F)<br><b>Altimeter Setting:</b> _____ in. Hg<br>or _____ MB |
| <b>Lowest Cloud Condition Height</b><br>_____ ft agl                                                                                                                                                                                                                                         | <b>Ceiling Height</b><br>11000 _____ ft agl                                                                                                                                                                                     |                                                                                                                                                 |

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

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

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

DAMAGE TO AIRCRAFT AND OTHER PROPERTY

|                                                                                                                                                                                                   |                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Aircraft Damage</b><br><input type="radio"/> None <input type="radio"/> Substantial<br><input type="radio"/> Minor <input checked="" type="radio"/> Destroyed<br><input type="radio"/> Unknown | <b>Aircraft Fire</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Fire at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown | <b>Aircraft Explosion</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Explosion at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

COMPLETE LOSS OF AIRCRAFT. CARS DAMAGED (PER NEWS REPORT).

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.

FLYING THE NYC SFRA (HUDSON RIVER).  
ENTERED FROM THE NORTH.  
FLEW SOUTH ALONG THE SHORES OF NEW JERSEY.  
BETWEEN THE STATUE OF LIBERTY AND THE VERRANZANO BRIDGE THERE WAS A MUTED NOISE FROM THE FRONT OF THE AIRCRAFT.  
THERE WAS AN IMMEDIATE DECREASE IN POWER.  
I SWITCH FUEL TANKS, I FOLLOW THE POWER LOSS CHECKLIST.  
I LOOK FOR A PLACE TO LAND.  
I RADIO A MAYDAY.  
MY FIRST CHOICE FOR LANDING IS TOO ROUGH, I FLY TO A SECOND CHOICE, A ROAD, IT HAS TOO MUCH TRAFFIC, AS I TURN I SEE ANOTHER STREET, WHICH INITIALLY LOOKS GOOD (NOT A LOT OF TRAFFIC) BUT THERE ARE POWERLINES AHEAD AND TREES TO THE RIGHT.  
I HIT THE POWERLINES.

|                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| RECOMMENDATION (How could this accident/incident have been prevented?)                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Operator/Owner Safety Recommendation                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
|                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| MECHANICAL MALFUNCTION/FAILURE (If more space is needed, continue on separate sheet)                                                                                                                     |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Was there Mechanical Malfunction/Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.) |                                                                                                                                                                                                                                                                                                                                         | Total Time/Cycles On Part<br><br>_____ Hours<br>_____ Cycles                                                                                                        |
|                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                         | Time Since This Part Inspected/Overhauled<br><br>_____ Hours                                                                                                        |
| FUEL & SERVICES INFORMATION                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Fuel on Board at Last Takeoff<br>(Convert from pounds, as necessary)                                                                                                                                     | Fuel Type                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                     |
| 48 _____ Gallons                                                                                                                                                                                         | <input type="radio"/> 80/87 <input type="radio"/> 115/145 <input type="radio"/> Jet B <input type="radio"/> Other, specify _____<br><input checked="" type="radio"/> 100 Low Lead <input type="radio"/> Jet A <input type="radio"/> JP8<br><input type="radio"/> 100/130 <input type="radio"/> Jet A-1 <input type="radio"/> Automotive |                                                                                                                                                                     |
| Other Services, if Any, Prior to Departure                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
|                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| EVACUATION OF AIRCRAFT                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Was an emergency evacuation of the aircraft performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                               |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Method of Exit – Describe how the occupants exited and how many occupants evacuated each location                                                                                                        |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| CUT OUT BY FIRE DEPARTMENT                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| OTHER AIRCRAFT – COLLISION (If air or ground collision occurred, complete this section for other aircraft)                                                                                               |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                     |
| Aircraft Registration Number                                                                                                                                                                             | Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                     | Damage to Other Aircraft<br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> 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**

|                                                                              |                                                                                                                                                                                 |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Date of this Report</b><br><u>03/14/2017</u><br><small>mm/dd/yyyy</small> | <b>Name of Pilot/Operator:</b> <u>GEORGE PETTWAY</u><br><b>Signature:</b> _____<br>-- or -- <input checked="" type="checkbox"/> Check here to electronically sign this document |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**If a Person Other than Pilot/Operator is Filing Report**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

-- or -- ☐ Check here to electronically sign this document

**FOR NTSB USE ONLY**

|                                                       |                                                       |                                               |                                               |
|-------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <b>NTSB Accident/Incident No.</b><br><u>EDAT14110</u> | <b>Reviewed by NTSB Regional Office</b><br><u>ERA</u> | <b>Name of Investigator</b><br><u>L. READ</u> | <b>Date Report Received</b><br><u>3/14/17</u> |
|-------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|