

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

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

| BASIC INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|-----------------------------------------------|--|---------------------------------------------|--|
| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>Smethport</u> State: <u>PA</u><br>ZIP: <u>16749</u> Country: <u>United States</u><br>Latitude: _____ (dd mm ss N/S) Longitude: _____ (ddd mm ss E/W)                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            | <b>Date/Time</b><br>Date: <u>04/08/18</u> Local Time: <u>5:00 pm</u><br><small>mm/dd/yyyy</small> Time Zone: <u>Eastern</u>                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Phase of Operation</b><br><input type="checkbox"/> Standing <input type="checkbox"/> Takeoff (incl. initial climb) <input type="checkbox"/> Cruise <input checked="" type="checkbox"/> Hover<br><input type="checkbox"/> Taxi <input type="checkbox"/> Climb <input type="checkbox"/> Maneuvering <input type="checkbox"/> Other<br><input type="checkbox"/> Descent <input type="checkbox"/> Landing <input type="checkbox"/> Approach <input type="checkbox"/> Unknown |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            | <b>Collision with Other Aircraft</b><br><input type="checkbox"/> Midair<br><input type="checkbox"/> On-ground<br><input checked="" type="checkbox"/> None                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Altitude of In-Flight Occurrence</b><br><u>1,900</u> ft MSL |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| AIRCRAFT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Manufacturer:</b> <u>McDonald Douglas</u><br><b>Model:</b> <u>600N</u><br><b>Serial Number:</b> _____<br><b>Registration Number:</b> <u>602BP</u> Amateur-built: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            | <b>Max Gross Weight:</b> _____ lbs<br><b>Weight at Time of Accident/Incident:</b> _____ lbs<br><b>Location of Center of Gravity at Time of Accident/Incident:</b><br>_____ inches from <input type="checkbox"/> nose or <input type="checkbox"/> datum<br>-or- _____ Percent Mean Aerodynamic Cord (% MAC) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Category of Aircraft</b><br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Blimp/Dirigible<br><input type="checkbox"/> Glider<br><input checked="" type="checkbox"/> Gyrocraft<br><input checked="" type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered lift<br><input type="checkbox"/> Ultralight<br><input type="checkbox"/> Unknown                                                                  |  | <b>Type of Airworthiness Certificate</b><br><i>(Check all that apply)</i><br><b>Standard</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Utility<br><input type="checkbox"/> Acrobatic<br><input type="checkbox"/> Transport<br><b>Special</b><br><input type="checkbox"/> Restricted<br><input type="checkbox"/> Limited<br><input type="checkbox"/> Provisional<br><input type="checkbox"/> Experimental<br><input type="checkbox"/> Special Flight<br><input type="checkbox"/> Light Sport |                                                                                                                                                                                                                                                                                    | <b>Number of Seats:</b> <u>4</u><br>If Large Aircraft, how many seats for:<br>Flight Crew: _____<br>Cabin Crew: _____<br>Passengers: _____ |                                                                                                                                                                                                                                                                                                            | <b>Landing Gear</b> <input type="checkbox"/> Retractable<br>Check any additional landing gear configuration that applies:<br><input type="checkbox"/> Tricycle <input type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input checked="" type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input checked="" type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Unknown |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Type of Maintenance Program</b><br><input type="checkbox"/> Annual<br><input type="checkbox"/> Conditional (Amateur-built only)<br><input type="checkbox"/> Manufacturer's Inspection Program<br><input type="checkbox"/> Other Approved Inspection Program (AAIP)<br><input checked="" type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> Other, specify: _____                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Last Inspection Type</b><br><input checked="" type="checkbox"/> 100 Hour <input type="checkbox"/> Continuous Airworthiness<br><input type="checkbox"/> AAIP <input type="checkbox"/> Conditional Inspection<br><input type="checkbox"/> Annual <input type="checkbox"/> Unknown |                                                                                                                                            | <b>Date Last Inspection:</b> _____<br><small>mm/dd/yyyy</small><br><b>Airframe Total Time:</b> _____ hrs<br>hours measured at (check one)<br><input type="checkbox"/> Last Inspection <input type="checkbox"/> Time of Accident/Incident                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>IFR Equipped</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Stall Warning System Installed</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown                                                                                                                                      |                                                                                                                                            | <b>Type of Fire Extinguishing System</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Specify _____                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>ELT Installed</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>ELT Activated</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>ELT Manufacturer:</b> _____<br><b>Model/Series:</b> _____<br><b>Serial Number:</b> _____<br><b>Battery Type:</b> _____ <b>Battery Exp. Date:</b> _____                                                                                                                          |                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>ELT Aided in Locating Accident/Incident</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Engine Type</b><br><input type="checkbox"/> Reciprocating <input type="checkbox"/> Turbo Jet<br><input checked="" type="checkbox"/> Turbo Shaft <input type="checkbox"/> Turbo Fan<br><input type="checkbox"/> Turbo Prop <input type="checkbox"/> Unknown                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Reciprocating Fuel System Type</b><br><input type="checkbox"/> Carburetor<br><input type="checkbox"/> Fuel Injected                                                                                                                                                             |                                                                                                                                            | <b>Propeller</b><br><input type="checkbox"/> Fixed Pitch <input type="checkbox"/> Controllable Pitch<br>Manufacturer: _____<br>Model: _____                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                |                                                  |  |                                                                                                                                       |  |                                    |  |                                               |  |                                             |  |
| <b>Engine</b><br>Eng. 1 <u>Rolls Royce</u><br>Eng. 2   _____<br>Eng. 3   _____<br>Eng. 4   _____                                                                                                                                                                                                                                                                                                                                                                            |  | <b>Engine Manufacturer</b><br><u>C47</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                    | <b>Engine Model/Series</b><br>_____                                                                                                        |                                                                                                                                                                                                                                                                                                            | <b>Manufacturer's Serial Number</b><br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                | <b>Date of Mfg.</b><br><small>mm/dd/yyyy</small> |  | <b>Engine Rated Power Measured as (check one)</b><br><input type="checkbox"/> Horsepower or<br><input type="checkbox"/> lbs of Thrust |  | <b>Total Time (hours)</b><br>_____ |  | <b>Time Since Inspection (hours)</b><br>_____ |  | <b>Time Since Overhaul (hours)</b><br>_____ |  |

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

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

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

Airport Identifier: KBFD Distance From Airport Center: 15 SM  
 Airport Name: Bradford Regional Direction From Airport: 090 degrees MAG  
 Proximity to Airport ☒ Off Airport/Airstrip ☐ On Airport ☐ On Airstrip Airport Elevation: 2,000 ft. MSL

**Approach Segment** (Select one)

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

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

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

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

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

**Runway Information**

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

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

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

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

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

**FLIGHT ITINERARY INFORMATION**

**Last Departure Point**

Airport ID: KBFD  
 City: Bradford  
 State: PA  
 Country: United States

**Time of Departure**

Time: 0800  
 Time Zone: Eastern

**Destination**

Airport ID: KBFD  
 City: Bradford  
 State: PA  
 Country: United States

**Type Flight Plan Filed**

☒ None ☐ VFR/IFR  
☐ Company VFR ☐ IFR  
☐ Military VFR ☐ Unknown  
☐ VFR  
 Activated? ☐ Yes ☐ No

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

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

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

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

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

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

**FUEL & SERVICES INFORMATION**

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

60 Gallons

**Fuel Type**

☐ 80/87 ☒ 15/145 ☐ JP3 ☐ Other, specify \_\_\_\_\_  
☐ 100 Low Lead ☒ Jet A ☐ JP4  
☐ 100/130 ☐ Automotive ☐ JP5

**Other Services, if Any, Prior to Departure**

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

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

**WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE****Weather Observation Facility**Facility ID: KBEVObservation Time: 1000Time Zone: EasternDistance from Accident Site: 15 NMDirection from Accident Site: 090 degrees MAG**Source of Weather Information**

(Check all that apply)

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

**Method of Briefing**

(Check all that apply)

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

**Briefing Type/Completeness**

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

**Light Condition**

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

**Visibility**10 miles**Sky/Lowest Cloud Condition**

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

**Ceiling**

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

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

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

**Lowest Cloud Condition Height**

ft AGL

**Ceiling Height**

ft AGL

**Wind Direction**

- ☐ Indicated: 300 degrees MAG
- ☐ Variable

**Wind Speed**

- Velocity: 10 KTS
- or-
- ☐ Calm
- ☐ Light and Variable

**Wind Gusts**

- Velocity: 15 KTS
- ☒ Gusting
- ☐ Not Gusting

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

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

**Severity of Turbulence**

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

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

Temperature: 3 (C)  
or 38 (F)Altimeter Setting: 29.96 in. HG  
or \_\_\_\_\_ MB

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

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

- | Amount                                   | Type                              |
|------------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Rime     |
| <input type="checkbox"/> Trace           | <input type="checkbox"/> Clear    |
| <input type="checkbox"/> Light           | <input type="checkbox"/> Moderate |
|                                          | <input type="checkbox"/> Severe   |

**Icing Actual**

- | Amount                                   | Type                              |
|------------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Rime     |
| <input type="checkbox"/> Trace           | <input type="checkbox"/> Clear    |
| <input type="checkbox"/> Light           | <input type="checkbox"/> Moderate |
|                                          | <input type="checkbox"/> Severe   |
|                                          | <input type="checkbox"/> Mixed    |

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

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

**Intensity of Precipitation**

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

| PILOT "A" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
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| <b>Pilot "A" Responsibilities at the Time of Accident/Incident</b><br><input checked="" type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Pilot "A" Identification</b><br>First Name: <u>Chase</u> City: <u>Toquerville</u><br>Middle Initial: <u>N</u> State: <u>UT</u> ZIP: <u>84774</u><br>Last Name: <u>Olsen</u> Country: <u>United States</u><br>Age at time of Accident/Incident: <u>30</u> Date of Birth: <span style="background-color: black; color: black;">[REDACTED]</span> Certificate Number: <span style="background-color: black; color: black;">[REDACTED]</span><br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input checked="" type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                                    | <b>Seat Occupied</b><br><input checked="" type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | <b>Seat Belt</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              |           |                                                                                                                       | <b>Shoulder Harness</b><br>Used <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Pilot Certificate(s) (Check all that apply)</b><br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Principal Occupation</b><br><input checked="" type="checkbox"/> Pilot<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input type="checkbox"/> Class 3<br><input type="checkbox"/> Class 1 <input type="checkbox"/> Driver's License (Sport Pilot only)<br><input checked="" type="checkbox"/> Class 2 <input type="checkbox"/> Unknown                                                                      |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               | <b>Medical Certificate Validity</b><br><input checked="" type="checkbox"/> Without limitations/waivers<br><input type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | <b>Date of Last Medical</b><br><u>04/07/17</u><br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div> |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Medical Certificate Limitations</b><br><u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Medical Certificate Waivers</b><br><u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____<br><div style="text-align: center; font-size: small;">mm/dd/yyyy</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | <b>Other Aircraft Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Free Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input checked="" type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                                                                                                     | <b>Instrument Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input checked="" type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                                 | <b>Instructor Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><div style="float: right;"> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input checked="" type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport           </div> |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | <b>Student Endorsements (Include dates)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| <table border="1" style="width:100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th rowspan="2">Flight Time (enter appropriate number of hours in each box)</th> <th rowspan="2">All Aircraft</th> <th rowspan="2">This Make &amp; Model</th> <th rowspan="2">Airplane Single Engine</th> <th rowspan="2">Airplane Multiengine</th> <th rowspan="2">Night</th> <th colspan="2">Instrument</th> <th rowspan="2">Rotorcraft</th> <th rowspan="2">Glider</th> <th rowspan="2">Lighter Than Air</th> </tr> <tr> <th>Actual</th> <th>Simulated</th> </tr> </thead> <tbody> <tr> <td>Total Time</td> <td>6200</td> <td>200</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>6200</td> <td></td> <td></td> </tr> <tr> <td>Pilot in Command (PIC)</td> <td>6130</td> <td>200</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>6130</td> <td></td> <td></td> </tr> <tr> <td>Time as Instructor</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>This Make/Model</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Last 90 Days</td> <td>150</td> <td>100</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>150</td> <td></td> <td></td> </tr> <tr> <td>Last 30 Days</td> <td>50</td> <td>50</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>50</td> <td></td> <td></td> </tr> <tr> <td>Last 24 Hours</td> <td>4</td> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>4</td> <td></td> <td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  | Flight Time (enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time | 6200 | 200 |  |  |  |  |  | 6200 |  |  | Pilot in Command (PIC) | 6130 | 200 |  |  |  |  |  | 6130 |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days | 150 | 100 |  |  |  |  |  | 150 |  |  | Last 30 Days | 50 | 50 |  |  |  |  |  | 50 |  |  | Last 24 Hours | 4 | 4 |  |  |  |  |  | 4 |  |  |
| Flight Time (enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                                  | Airplane Single Engine                                                                                                                                                                                                                                              | Airplane Multiengine                                                                                                                                                                                                          | Night                                                                                                                                                                                           | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |           | Rotorcraft                                                                                                            | Glider                                                                                                                                                                    | Lighter Than Air |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Simulated |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6200         | 200                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | 6200                                                                                                                  |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6130         | 200                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | 6130                                                                                                                  |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           |                                                                                                                       |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 150          | 100                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | 150                                                                                                                   |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 50           | 50                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | 50                                                                                                                    |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4            | 4                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |           | 4                                                                                                                     |                                                                                                                                                                           |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |      |     |  |  |  |  |  |      |  |  |                        |      |     |  |  |  |  |  |      |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |     |  |  |  |  |  |     |  |  |              |    |    |  |  |  |  |  |    |  |  |               |   |   |  |  |  |  |  |   |  |  |

| PILOT "B" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
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| <b>Pilot "B" Responsibilities at the Time of Accident/Incident</b><br><input type="checkbox"/> Pilot <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Student Pilot <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Check Pilot <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot "B" Identification</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br>Age at time of Accident/Incident: _____ Date of Birth: _____ mm/dd/yyyy Certificate Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="checkbox"/> None <input type="checkbox"/> Fatal<br><input type="checkbox"/> Minor <input type="checkbox"/> Unknown<br><input type="checkbox"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                  | <b>Seat Occupied</b><br><input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Unknown<br><input type="checkbox"/> Right <input type="checkbox"/> Rear<br><input type="checkbox"/> Center <input type="checkbox"/> Single |                                                                                                                                                                                                             |                                                                                                                                                                                      | <b>Seat Belt</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                   |                                                 | <b>Shoulder Harness</b><br>Used <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Available <input type="checkbox"/> Yes <input type="checkbox"/> No |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Student <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Flight Engineer <input type="checkbox"/> Foreign<br><input type="checkbox"/> Private <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Sport <input type="checkbox"/> Airline Transport <input type="checkbox"/> U.S. Military                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="checkbox"/> Pilot<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              | <b>Medical Certificate</b><br><input type="checkbox"/> None <input type="checkbox"/> Class 3<br><input type="checkbox"/> Class 1 <input type="checkbox"/> Driver's License (Sport Pilot only)<br><input type="checkbox"/> Class 2 <input type="checkbox"/> Unknown                                                               |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             | <b>Medical Certificate Validity</b><br><input type="checkbox"/> Without limitations/waivers<br><input type="checkbox"/> With limitations/waivers<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Date of Last Medical</b><br>_____ mm/dd/yyyy |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Waivers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____ mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | <b>Other Aircraft Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Free Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                                                                                          | <b>Instrument Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                                                                                                                                      | <b>Instructor Rating(s)</b><br>(Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Airplane Single-Engine <input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Airplane Multi-Engine <input type="checkbox"/> Helicopter<br><input type="checkbox"/> Gyroplane <input type="checkbox"/> Glider<br><input type="checkbox"/> Powered Lift <input type="checkbox"/> Sport |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      | <b>Student Endorsements</b> (Include dates)                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;">Flight Time (enter appropriate number of hours in each box)</th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 5px;">Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  | Flight Time (enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time (enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                | Airplane Single Engine                                                                                                                                                                                                                                   | Airplane Multiengine                                                                                                                                                                                        | Night                                                                                                                                                                                | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                 | Rotorcraft                                                                                                                                                     | Glider | Lighter Than Air |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Simulated                                       |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                             |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                |        |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

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

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

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

At approximately 0800 Eastern, I departed Bradford Regional Airport (KBFD) for work on a transmission line east of the airfield. Upon reaching the L.Z. at the work location, I shut down to get briefed on the job tasks needed for the day. The job task was to clip in the fiber optic line from the dolly to the structure. This task required the lineman to be on the skid while attached to the side of the helicopter. There was also to be another lineman secured in the cargo area of the helicopter to help the lineman on the skid. After a briefing on what to do and mitigating risk factors, we proceeded to go to work. We successfully clipped two structures with a fuel stop in between we moved onto the third structure. The third structure was a slight inside angle but still deemed safe to clip. While on the first process of clipping in, the lineman manipulated the dolly to the point where the fiber optic line came out of the dolly. When this happened, it landed on the skid of the helicopter causing a dynamic rollover in the air.

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

Operator/Owner Safety Recommendation

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

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

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE****Date of this Report**05/03/18  
*mm/dd/yyyy***Signature and Name of Pilot/Operator**Signature: Type or Print Name: Chase Olsen**Signature and Name of Person Filing Report if Other than Pilot/Operator**

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

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

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

**FOR NTSB USE ONLY****NTSB Accident/Incident No.**  
ERA18FA122**Reviewed by NTSB Regional Office**  
Ashburn, VA**Name of Investigator**  
Rayner**Date Report Received**  
05/04/2018