

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

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

## BASIC INFORMATION

### Accident/Incident Location

Nearest City/Place: Fort Lauderdale State: FL

ZIP: \_\_\_\_\_ Country: US

Latitude: 26° 7'14.30"N Longitude: 80° 8'22.75"W

(Enter in decimal degrees or degrees:minutes:seconds)

### Accident/Incident Date/Time

Date: 01/24/2018 Local Time: 16:56

mm/dd/yyyy

Time Zone: Eastern

Collision with Other Aircraft: ☐ Midair ☐ On-ground ☒ None

## AIRCRAFT INFORMATION

Registration Number: N3947C

Manufacturer: SCHWEIZER AIRCRAFT

Model: 269C-1 Helicopter

Serial Number: 0343

Year of Manufacture: 2008

Amateur-Built: ☐ Yes ☒ No If Yes: ☐ Kit/Plans ☐ Original Design Make: \_\_\_\_\_

☒ IFR-Equipped and Certified

☐ Commercial Space Flight

☐ Unmanned Aircraft

Maximum Gross Weight: 1750 lbs

Weight at Time of Accident/Incident: 1619 lbs

Number of Seats: 2 Flight Crew Seats: NA

Cabin Crew Seats: 2 Passenger Seats: NA

Number of Engines: 1

### Category of Aircraft

- ☐ Airplane
- ☐ Balloon
- ☐ Blimp/Dirigible
- ☐ Glider
- ☐ Gyroplane
- ☒ Helicopter
- ☐ Powered Lift
- ☐ Rocket
- ☐ Ultralight
- ☐ Unknown

### Type of Airworthiness Certificate

(Check all that apply)

#### Standard

- ☒ Normal
- ☐ Aerobatic
- ☐ Balloon
- ☐ Commuter
- ☐ Transport
- ☐ Utility

#### Special

- ☐ Restricted
- ☐ Limited
- ☐ Provisional
- ☐ Special Flight
- ☐ Experimental
- ☐ Special Light-Sport
- ☐ Experimental Light-Sport

- ☐ Certificate of Authorization or Waiver (COA)
- ☐ None
- ☐ Unknown

### Landing Gear

(Check all that apply)

☐ Retractable

- ☐ Tricycle
- ☐ Amphibian
- ☐ Emergency Float
- ☐ Float
- ☐ Hull
- ☐ Other Launch/Recovery System
- ☐ None
- ☐ Tailwheel
- ☐ High Skid
- ☒ Skid
- ☐ Ski
- ☐ Ski/Wheel
- ☐ Unknown

### Engine Type (Select one)

- ☒ Reciprocating
- ☐ Turbo Shaft
- ☐ Turbo Prop
- ☐ Turbo Jet
- ☐ Turbo Fan
- ☐ Electric
- ☐ Liquid Rocket
- ☐ Solid Rocket
- ☐ Hybrid Rocket
- ☐ None
- ☐ Unknown

### Fuel System Type (Reciprocating)

- ☐ Carburetor
- ☒ Fuel-Injected

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br>mm/dd/yyyy | Rated Power<br><input checked="" type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time<br>(hours) | Time Since:<br>Inspection<br>(hours) | Overhaul<br>(hours) |
|--------|---------------------|---------------------|------------------------------|----------------------------|------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------|
| Eng. 1 | Textron Lycoming    | HIO-360-G1A         | L340 63-51A                  | 01/31/2008                 | 180                                                                                                  | 2297.0                | 69.1                                 | 297.1               |
| Eng. 2 | --                  |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 3 | --                  |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 4 | --                  |                     |                              |                            |                                                                                                      |                       |                                      |                     |

### Last Inspection Type

- ☐ 100-Hour
- ☐ AAIP
- ☒ Annual
- ☐ Continuous Airworthiness
- ☐ Conditional Inspection
- ☐ Unknown

Date Last Inspection: 09/27/2017  
mm/dd/yyyy

Airframe Total Time: 2297.0 hrs

hours measured at (Select one)

- ☐ Last Inspection
- ☒ Time of Accident/Incident

### Type of Maintenance Program (Select one)

- ☒ Annual
- ☐ Conditional (Amateur-built only)
- ☐ Manufacturer's Inspection Program
- ☐ Other Approved Inspection Program (AAIP)
- ☐ Continuous Airworthiness
- ☐ Other, specify: \_\_\_\_\_

### Description of Fire Extinguishing System

- ☐ None
- ☒ Specify:

### Propeller 1

- ☐ Fixed Pitch
- ☐ Controllable Pitch
- ☐ Ground Adjustable

Manufacturer: NA

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

### Propeller 2

- ☐ Fixed Pitch
- ☐ Controllable Pitch
- ☐ Ground Adjustable

Manufacturer: --

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

ELT Installed: ☐ Yes ☒ No

If Yes:

ELT Manufacturer: --

Model or Part No.: \_\_\_\_\_

TSO No.: ☐ OC91 (121.5 MHz) ☐ OC91a (121.5 MHz)  
☐ OC126 (406 MHz)

Was ELT still mounted in aircraft? ☐ Yes ☐ No

Was ELT still connected to antenna? ☐ Yes ☐ No

Did ELT Activate? ☐ Yes ☐ No

If activated:

Did ELT Aid in Locating Aircraft? ☐ Yes ☐ No

If not activated:

- Indicate Reason:
- ☐ Impact Damage
  - ☐ Fire Damage
  - ☐ Battery Expired/Damaged
  - ☐ Unknown

### Additional Equipment (Check all that apply)

- ☐ ADS-B
- ☐ Airframe Parachute
- ☐ Angle of Attack Indicator
- ☐ Autopilot
- ☐ Data Recorder
- ☐ Electronic Flight Bag or Handheld Device
- ☐ Electronic Multifunction Display
- ☐ Electronic Primary Flight Display
- ☐ Handheld GPS
- ☐ Heads Up Display
- ☐ Onboard Weather
- ☐ Satellite Tracking Device
- ☐ Stall Warning System
- ☐ Video Recording Device
- ☒ Other, Specify: GPS Garmin 430

**OWNER/OPERATOR INFORMATION****Registered Aircraft Owner**Name: Helocraft Holding IncCity: Pembroke PinesState: FLZIP: 33023Fractional Ownership Aircraft: ☐ Yes ☒ NoCountry: USA**Operator of Aircraft**☐ Same As Registered Owner☒ Same Address as Registered OwnerName: Pelican Flight Training LLC

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

Doing Business As: same

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

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

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

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

**Operating Certificates Held**

(Check all that apply)

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

**Regulation Flight Conducted Under**

- ☒ FAR 91 ☐ FAR 129 ☐ FAR 415  
☐ FAR 103 ☐ FAR 133 ☐ FAR 431  
☐ FAR 121 ☐ FAR 135 ☐ FAR 435  
☐ FAR 125 ☐ FAR 137 ☐ FAR 437
- ☐ FAR 91 Special Flight  
☐ Non-US, Commercial  
☐ Non-US, Non-commercial
- ☐ Public Aircraft (Select one)  
☐ Armed Forces  
☐ Federal  
☐ State  
☐ Local  
☐ Unknown

**Revenue Operation for FAR 121, 125, 129, 135**

(Select one for each group)

- ☐ Scheduled or Commuter ☐ Domestic  
☐ Non-Scheduled or Air Taxi ☐ International
- ☐ Passenger  
☐ Cargo  
☐ Mail Contract Only

**Purpose of Flight for FAR 91, 103, 133, 137**

(Select one)

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

**Revenue Sightseeing Flight**☐ Yes ☒ No**Air Medical Flight**☐ Yes ☒ No**AIRPORT INFORMATION (Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)**Airport Name: Downtown Fort Lauderdale HeliportDistance From Airport Center: 0.1 smAirport Identifier: DT1Direction From Airport: 84 degrees trueProximity to Airport: ☒ Off Airport/Airstrip ☐ On Airport/Airstrip ☐ N/AAirport Elevation: 114 ft. msl**Runway Information**Runway ID: NA (L/R/C) Length: NA ft Width: NA ft**Runway/Landing Surface (Check all that apply)**

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

**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  
☐ Slush-Covered ☐ Vegetation ☐ Unknown

**Approach/Departure Segment (Select one)**

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

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

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

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

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

### **“Flight Crewmember 1” Responsibilities at the Time of Accident/Incident**

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

### “Flight Crewmember 1” Identification

First Name: Alex

City of Residence: Delray Beach

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

State: Florida ZIP: 33445

Last Name: Marshall

Country: USA

Age at time of Accident/Incident: 48 Date of Birth: mm/dd/yyyy

Certificate Number: [REDACTED]

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                       |                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Degree of Injury</b><br><input checked="" type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                             | <b>Seat Occupied</b><br><input checked="" type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single |                                                                                                                                                                                                                                                         | <b>Restraint Type</b><br><div> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input checked="" type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown         </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input checked="" type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown         </div> |                                                                       | <b>Inflatable Restraints</b><br><input checked="" type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div> <input type="checkbox"/> None    <input checked="" type="checkbox"/> Flight Instructor    <input checked="" type="checkbox"/> Commercial    <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Private    <input type="checkbox"/> Recreational    <input type="checkbox"/> Airline Transport    <input type="checkbox"/> Foreign<br/> <input type="checkbox"/> Student    <input type="checkbox"/> Sport    <input type="checkbox"/> Flight Engineer         </div> |                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                       |                                                                                                                                                                                                                                           |
| <b>Principal Occupation</b><br><input checked="" type="radio"/> Pilot<br><input type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input checked="" type="radio"/> Class 2 <input type="radio"/> Unknown |                                                                                                                                                                                                                                                | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input checked="" type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Date of Last Medical</b><br><u>05/25/2017</u><br><i>mm/dd/yyyy</i> |                                                                                                                                                                                                                                           |

corrective lenses

## Medical Certificate Special Issuance

|                                                                                                                       |                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>05/20/2017</u><br><i>mm/dd/yyyy</i> | <b>Flight Review Aircraft</b><br><b>Make:</b> <u>Shcweizer 2008</u><br><b>Model:</b> <u>269C-1</u> |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><br><input checked="" 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><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input 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><input type="checkbox"/> Instrument Airplane<br><input checked="" type="checkbox"/> Instrument Helicopter<br><input checked="" type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| Type Ratings | Student Endorsements <i>(Include dates)</i> |
|--------------|---------------------------------------------|
|              |                                             |

| 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                                                  | 700          | 244               | 0                      | 0                    | 62    |            | 72        | 700        | 0      | 0                |
| Pilot in Command (PIC)                                      | 631          | 244               | 0                      | 0                    | 59    |            | 72        | 636        | 0      | 0                |
| Time as Instructor                                          | 373          | 237               | 0                      | 0                    | 32    |            | 0         | 373        | 0      | 0                |
| This Make/Model                                             |              |                   |                        |                      | 28    |            | 13        |            |        |                  |
| Last 90 Days                                                | 115          | 74                | 0                      | 0                    | 5     |            | 0         | 115        | 0      | 0                |
| Last 30 Days                                                | 39           | 24                | 0                      | 0                    | 0     |            | 0         | 39         | 0      | 0                |
| Last 24 Hours                                               | 1            | 1                 | 0                      | 0                    | 0     |            | 0         | 1          | 0      | 0                |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------|-------------------------|
| <b>“Flight Crewmember 2” Responsibilities at the Time of Accident/Incident</b><br><div><input type="radio"/> Pilot    <input type="radio"/> Co-Pilot    <input checked="" type="radio"/> Student Pilot    <input type="radio"/> Flight Instructor    <input type="radio"/> Check Pilot    <input type="radio"/> Flight Engineer    <input type="radio"/> Other Flight Crew</div> <b>“Flight Crewmember 2” was pilot flying</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>“Flight Crewmember 2” Identification</b><br>First Name: <u>Sultan</u> City of Residence: <u>Aqtobe</u><br>Middle Initial: _____    State: <u>Kazakhstan</u> ZIP: _____<br>Last Name: <u>Saidmuratov</u> Country: <u>Kazakhstan</u><br>Age at time of Accident/Incident: <u>26</u> Date of Birth: <u>          1991          </u> <i>mm/dd/yyyy</i><br>Certificate Number: <u>NA</u>                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Degree of Injury</b><br><input checked="" type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                         |  | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input checked="" type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single                                                                                                |                                                                      |                                                                                                                                                                                                                               | <b>Restraint Type</b><br><div><b>Available</b><br/><input type="radio"/> None<br/><input type="radio"/> Lap only<br/><input type="radio"/> 3-point<br/><input checked="" type="radio"/> 4-point<br/><input type="radio"/> 5-point<br/><input type="radio"/> Unknown</div> <div><b>Used</b><br/><input type="radio"/> None<br/><input type="radio"/> Lap only<br/><input type="radio"/> 3-point<br/><input checked="" type="radio"/> 4-point<br/><input type="radio"/> 5-point<br/><input type="radio"/> Unknown</div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | <b>Inflatable Restraints</b><br><input checked="" type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                   |               |                         |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer        |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input checked="" type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                              |  | <b>Medical Certificate</b><br><input checked="" type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver’s License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                                   |                                                                      |                                                                                                                                                                                                                               | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input checked="" type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   | <b>Date of Last Medical</b><br><u>NA</u><br><i>mm/dd/yyyy</i>                                                                                                                                                                             |                   |               |                         |
| <b>Medical Certificate Limitations</b><br><u>NA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Medical Certificate Special Issuance</b><br><u>NA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>NA</u><br><i>mm/dd/yyyy</i>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                               | <b>Flight Review Aircraft</b><br>Make: <u>NA</u><br>Model: <u>NA</u> |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><br><input checked="" 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><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                                                                      | <b>Instrument Rating(s)</b><br><i>(Check all that apply)</i><br><input checked="" 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><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Student Endorsements</b> <i>(Include dates)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                   |                                                                                                                                                                                                                                           |                   |               |                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                                                                                                           |                   |               |                         |
| <b>Flight Time</b> <i>(Enter appropriate number of hours in each box)</i>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>All Aircraft</b>                                                                                                                                                                                                                                                                                                                           | <b>This Make &amp; Model</b>                                         | <b>Airplane Single Engine</b>                                                                                                                                                                                                 | <b>Airplane Multiengine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Night</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Instrument</b> |                                                                                                                                                                                                                                           | <b>Rotorcraft</b> | <b>Glider</b> | <b>Lighter Than Air</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Actual</b>     | <b>Simulated</b>                                                                                                                                                                                                                          |                   |               |                         |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 37                                                                                                                                                                                                                                                                                                                                            | 1                                                                    | 36                                                                                                                                                                                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 1                 | 0             | 0                       |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 0                                                                                                                                                                                                                                                                                                                                             | 0                                                                    | 0                                                                                                                                                                                                                             | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 0                 | 0             | 0                       |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 0                                                                                                                                                                                                                                                                                                                                             | 0                                                                    | 0                                                                                                                                                                                                                             | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 0                 | 0             | 0                       |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           |                   |               |                         |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 37                                                                                                                                                                                                                                                                                                                                            | 1                                                                    | 36                                                                                                                                                                                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 1                 | 0             | 0                       |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21                                                                                                                                                                                                                                                                                                                                            | 1                                                                    | 21                                                                                                                                                                                                                            | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 1                 | 0             | 0                       |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 0                                                                                                                                                                                                                                                                                                                                             | 0                                                                    | 0                                                                                                                                                                                                                             | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0                 |                                                                                                                                                                                                                                           | 0                 | 0             | 0                       |

| ADDITIONAL FLIGHT CREWMEMBERS (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                          |  |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                          |                                                                                                                                                            | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                 | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                          |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student               </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport               </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer               </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign               </div> </div> |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> <div style="flex: 1;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> </div> |                                                                                                                                                                                                                 | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                          |  |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                          |  |
| <b>Crew Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Seat Occupied</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                 | <b>Injury</b>                                                                                                                                                                                                                  |                                                                                                                                                                          |  |
| First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                          |                                                                                                                                                            | <input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                 | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                     |                                                                                                                                                                          |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Private<br/> <input type="checkbox"/> Student               </div> <div> <input type="checkbox"/> Flight Instructor<br/> <input type="checkbox"/> Recreational<br/> <input type="checkbox"/> Sport               </div> <div> <input type="checkbox"/> Commercial<br/> <input type="checkbox"/> Airline Transport<br/> <input type="checkbox"/> Flight Engineer               </div> <div> <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Foreign               </div> </div> |  |  |                                                                                                                                          |                                                                                                                                                            | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> <div style="flex: 1;"> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap Only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> </div> |                                                                                                                                                                                                                 | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |                                                                                                                                                                          |  |
| <b>Type Rating/Endorsement for Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | <b>Total Flight Time at the Time of this Accident/Incident:</b> _____ hrs                                                                |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                          |  |
| PASSENGER(S) / OTHER PERSONNEL (Include cabin crew; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                          |  |
| <b>Name and Address</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | <b>Seat</b>                                                                                                                              | <b>Injury</b>                                                                                                                                              | <b>Restraint Type</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                 | <b>Inflatable Restraints</b>                                                                                                                                                                                                   | <b>Age</b>                                                                                                                                                               |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                      |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                               | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                      |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                               | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                      |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                               | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |
| First Name: _____ City : _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 10px;"> <input type="radio"/> Crew    <input type="radio"/> Passenger    <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                      |  |  | <input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown | <b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                               | <b>Used</b><br><input type="radio"/> None<br><input type="radio"/> Lap Only<br><input type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown | <input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown                                 | <input type="checkbox"/> Under 5 years<br><i>If Under 5,</i><br><input type="radio"/> Child Restraint<br><input type="radio"/> Lap-Held<br><input type="radio"/> Unknown |  |

## FLIGHT ITINERARY INFORMATION

|                                                                                                                                       |                                                                             |                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                            |
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| <b>Last Departure Point</b><br>Airport ID: <u>DT1</u><br>City: <u>Fort Lauderdale</u><br>State: <u>Florida</u><br>Country: <u>USA</u> | <b>Time of Departure</b><br>Time: <u>16:55</u><br>Time Zone: <u>Eastern</u> | <b>Destination</b><br>Airport ID: <u>KHWO</u><br>City: <u>PEMBROKE PINES</u><br>State: <u>Florida</u><br>Country: <u>USA</u> | <b>Type Flight Plan Filed</b><br><input checked="" type="radio"/> None <input type="radio"/> VFR/IFR<br><input type="radio"/> Company VFR <input type="radio"/> IFR<br><input type="radio"/> Military VFR <input type="radio"/> Unknown<br><input type="radio"/> VFR<br><b>Activated?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
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|                                                             |                                      |                                      |                                               |                                       |
|-------------------------------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------------------|---------------------------------------|
| <b>Type of ATC Clearance/Service</b> (Check all that apply) |                                      |                                      |                                               |                                       |
| <input type="checkbox"/> None                               | <input type="checkbox"/> Special VFR | <input type="checkbox"/> Special IFR | <input type="checkbox"/> VFR Flight Following | <input type="checkbox"/> Cruise       |
| <input checked="" type="checkbox"/> VFR                     | <input type="checkbox"/> IFR         | <input type="checkbox"/> VFR On Top  | <input type="checkbox"/> Traffic Advisory     | <input type="checkbox"/> Unknown / NA |

|                                                                                                                                                                                             |                                                                                                                                                                                                         |                                                                                                                                                                                                                             |                                                                                                                           |
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| <b>Airspace where the accident/incident occurred</b> (Check all that apply)                                                                                                                 |                                                                                                                                                                                                         |                                                                                                                                                                                                                             | <b>Altitude of In-Flight Occurrence:</b><br><u>150</u> ft msl                                                             |
| <input type="checkbox"/> Class A<br><input type="checkbox"/> Class B<br><input checked="" type="checkbox"/> Class C<br><input type="checkbox"/> Class D<br><input type="checkbox"/> Class E | <input type="checkbox"/> Class G<br><input type="checkbox"/> Demo Area<br><input type="checkbox"/> Warning Area<br><input type="checkbox"/> Prohibited Area<br><input type="checkbox"/> Restricted Area | <input type="checkbox"/> Military Operations Area (MOA)<br><input type="checkbox"/> Airport Advisory Area<br><input type="checkbox"/> Jet Training Area<br><input type="checkbox"/> TRSA<br><input type="checkbox"/> FAR 93 | <input type="checkbox"/> Special<br><input type="checkbox"/> Air Traffic Control Area<br><input type="checkbox"/> Unknown |

## WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE

|                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Source of Pilot Weather Information</b><br>(Check all that apply)                                                                                                                                                                                                                                          | <b>Weather Observation Facility</b>                                                                                                                                                     |
| <input checked="" type="checkbox"/> National Weather Service<br><input type="checkbox"/> Flight Service Station<br><input type="checkbox"/> TV/Radio<br><input type="checkbox"/> Automated Report<br><input type="checkbox"/> Commercial Weather Service (DUATS)<br><input type="checkbox"/> On-Board Weather | Facility ID: <u>FLL</u><br>Observation Time: <u>2153Z</u><br>Time Zone: <u>ZULU</u><br>Distance from Accident Site: <u>3</u> nm<br>Direction from Accident Site: <u>15</u> degrees true |

|                                                                                                                               |                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night |
|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sky/Lowest Cloud Condition</b><br><input type="radio"/> Clear <input type="radio"/> Thin Broken<br><input type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input type="radio"/> Unknown<br><input checked="" type="radio"/> Scattered<br><b>Lowest Cloud Condition Height</b><br><u>2700</u> ft agl | <b>Ceiling</b><br><input type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input checked="" type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input type="radio"/> Unknown<br><b>Ceiling Height</b><br><u>6000</u> ft agl | <b>Temperature:</b> <u>23</u> (C) or _____ (F)<br><b>Dew Point:</b> <u>21</u> (C) or _____ (F)<br><b>Altimeter Setting:</b> <u>30.09</u> in. Hg<br>or _____ MB |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <b>Wind Direction</b><br><input type="checkbox"/> Variable<br>-or-<br>Direction: <u>030</u> degrees true | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>-or-<br>Speed: <u>8</u> kts | <b>Wind Gusts</b><br><input checked="" type="checkbox"/> Not Gusting<br>-or-<br>Speed: _____ kts | <b>Visibility</b> <u>10</u> miles<br>RVR: _____ feet<br>RVV: _____ miles<br><b>Density Altitude:</b> <u>1104</u> ft |
|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|

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

| <b>Icing Forecast</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Icing Actual</b>                  | <b>Turbulence</b> |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
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| <table border="0"> <tr> <th>Amount</th> <th>Type</th> </tr> <tr> <td><input checked="" type="radio"/> None</td> <td><input checked="" type="radio"/> N/A</td> </tr> <tr> <td><input type="radio"/> Trace</td> <td><input type="radio"/> Rime</td> </tr> <tr> <td><input type="radio"/> Light</td> <td><input type="radio"/> Clear</td> </tr> <tr> <td><input type="radio"/> Moderate</td> <td><input type="radio"/> Mixed</td> </tr> <tr> <td><input type="radio"/> Severe</td> <td><input type="radio"/> Unknown</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td></td> </tr> </table> | Amount                               | Type              | <input checked="" type="radio"/> None | <input checked="" type="radio"/> N/A | <input type="radio"/> Trace | <input type="radio"/> Rime | <input type="radio"/> Light | <input type="radio"/> Clear | <input type="radio"/> Moderate | <input type="radio"/> Mixed | <input type="radio"/> Severe | <input type="radio"/> Unknown | <input type="radio"/> Unknown |  | <table border="0"> <tr> <th>Amount</th> <th>Type</th> </tr> <tr> <td><input checked="" type="radio"/> None</td> <td><input checked="" type="radio"/> N/A</td> </tr> <tr> <td><input type="radio"/> Trace</td> <td><input type="radio"/> Rime</td> </tr> <tr> <td><input type="radio"/> Light</td> <td><input type="radio"/> Clear</td> </tr> <tr> <td><input type="radio"/> Moderate</td> <td><input type="radio"/> Mixed</td> </tr> <tr> <td><input type="radio"/> Severe</td> <td><input type="radio"/> Unknown</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td></td> </tr> </table> | Amount | Type | <input checked="" type="radio"/> None | <input checked="" type="radio"/> N/A | <input type="radio"/> Trace | <input type="radio"/> Rime | <input type="radio"/> Light | <input type="radio"/> Clear | <input type="radio"/> Moderate | <input type="radio"/> Mixed | <input type="radio"/> Severe | <input type="radio"/> Unknown | <input type="radio"/> Unknown |  | <table border="0"> <tr> <th>Type (Check all that apply)</th> <th>Severity</th> </tr> <tr> <td><input checked="" type="checkbox"/> None</td> <td><input type="checkbox"/> Light</td> </tr> <tr> <td><input type="checkbox"/> Clear Air</td> <td><input type="checkbox"/> Moderate</td> </tr> <tr> <td><input type="checkbox"/> Terrain-Induced</td> <td><input type="checkbox"/> Severe</td> </tr> <tr> <td><input type="checkbox"/> Convective Turbulence</td> <td><input type="checkbox"/> Extreme</td> </tr> </table> | Type (Check all that apply) | Severity | <input checked="" type="checkbox"/> None | <input type="checkbox"/> Light | <input type="checkbox"/> Clear Air | <input type="checkbox"/> Moderate | <input type="checkbox"/> Terrain-Induced | <input type="checkbox"/> Severe | <input type="checkbox"/> Convective Turbulence | <input type="checkbox"/> Extreme |
| Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Type                                 |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input checked="" type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="radio"/> N/A |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Trace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Rime           |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Light                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Clear          |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> Mixed          |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Severe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Unknown        |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                      |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Type                                 |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input checked="" type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="radio"/> N/A |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Trace                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Rime           |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Light                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Clear          |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Moderate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> Mixed          |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Severe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Unknown        |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                      |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| Type (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Severity                             |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input checked="" type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Light       |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="checkbox"/> Clear Air                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Moderate    |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="checkbox"/> Terrain-Induced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Severe      |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |
| <input type="checkbox"/> Convective Turbulence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Extreme     |                   |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |      |                                       |                                      |                             |                            |                             |                             |                                |                             |                              |                               |                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |          |                                          |                                |                                    |                                   |                                          |                                 |                                                |                                  |

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

Pls see the attached 3 pages

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

- ☐ None      ☒ Substantial  
☐ Minor      ☐ Destroyed  
                 ☐ Unknown

**Aircraft Fire**

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

**Aircraft Explosion**

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

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

As per visual - Landing Gears was deformed, Tail bum was separated

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

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

On January 24th, 2018, I was a Pilot In Command at Helicopter N3947C Schweizer 269C-1. The purpose of the flight was to provide a demonstration of flight and features of radio communications in Class C airspace to an ATC student during helicopter take-off, flight, and landing in urban conditions. The planned route of the flight was HWO - training aria A-291A - TD1 - shoreline - southbound – HWO. The plan was made with consideration of the current Airport/Facility Directory South West U.S. effective 12/17/2017 to 02/01/2018.

It was second flight of the day on this aircraft. No issues were evident during operations in the first flight. At the beginning of the lesson for the second flight, the preflight inspection was done, and a briefing on the objectives of the flight was completed. The helicopter's weight and balance were calculated. The take-off weight was 1655 pounds with 24.5 gallons of fuel. Center of gravity was within prescribed limits. The performance of the helicopter was determined according to Pilot's Flight Manual - In Ground Effect Hover Ceiling 3900 ft pressure altitude (26°C).

The Pilot's Flight Manual for this aircraft does not provide a table for calculating Hover Ceiling Out of Ground Effect. So takeoff from HWO was performed according to the maximum performance takeoff procedure. During takeoff, it was confirmed that with the current load, weather take-off direction 100°, wind direction 70°, wind speed 8kt, temperature 26°C and pressure 30.09, the helicopter has sufficient performance in order to hover out of Ground Effect with zero speed.

After approximately 35 minutes into the flight, a landing on DT1 had been conducted. The student left the helicopter with my permission, while the helicopter's engine continued to run at 2500 PRM. Student observed the pad environment and then returned on board to continue training. After the student returned into the helicopter, a hovering taxi towards the western circle takeoff location was conducted. Pre take off procedure was begun. During the hover, it was determined that the power required for hover was 26.5 inch MP and power available was 29.9 inch MP, leaving us with the excess power of 3.4 inch MP. Balance and flight control check was performed. Pre takeoff check was completed. Maximum performance takeoff was initiated.

As per normal scenario, the helicopter started to gain altitude and slightly move forward. The helicopter lost Ground Effect while still above the helipad. Approximately above the edge of the pad, the RPM unexpectedly started to drop. The Low RPM Horn sounded. As per the prescribed procedure for this situation, I slightly lowered the collective and added throttle. This did not bring the RPM back up. I lowered the collective once more and had full throttle. But the RPM continued to fall. The Low RPM horn became constant. Rotors RPM dropped below 340. We continued to settle and the rotor RPM continued to decay.

At that point, I made a decision to conduct an emergency landing. First, I significantly lowered the collective to prevent further decrease of RPM. Then taking in consideration the public area and busy traffic background of the site, I made my best choice to pick a safe place for an emergency landing, and announced "emergency landing" on the radio. The land was approaching. I executed an extremely short flare, level-off the aircraft, and pitched the collective. After the helicopter stopped moving I had shut off the fuel and the battery. Then, I made sure that the student did not suffer an injury, and we left the helicopter.

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

Operator/Owner Safety Recommendation

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

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

Lost of Power in the flight followed with Low RPM at the unknown reason

**Total Time/Cycles  
On Part**

\_\_\_\_\_ Hours

\_\_\_\_\_ Cycles

**Time Since This Part  
Inspected/Overhauled**

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**

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

18.5 Gallons

**Fuel Type**☐ 80/87☐ 115/145☐ Jet B☐ Other, specify \_\_\_\_\_☐ 100 Low Lead☐ Jet A☐ JP8☒ 100/130☐ Jet A-1☐ Automotive**Other Services, if Any, Prior to Departure****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

Helicopter blades were disassembled and aircraft was towed to the owner's maintenance hangar.

**OTHER AIRCRAFT – COLLISION (If air or ground collision occurred, complete this section for other aircraft)****Aircraft Registration Number**

NA

**Manufacturer:** \_\_\_\_\_**Model:** \_\_\_\_\_**Damage to Other Aircraft**☐ Destroyed☐ Minor☐ Substantial☐ None**Registered Owner of Other Aircraft**

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

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

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

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

**Pilot of Other Aircraft**

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

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

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

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

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

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

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

Date of this Report

02/02/2018

*mm/dd/yyyy*

Name of Pilot/Operator: Alex Marshall

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

-- or --



Check here to electronically sign this document

If a Person Other than Pilot/Operator is Filing Report

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

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

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

-- or --



Check here to electronically sign this document

**FOR NTSB USE ONLY**

NTSB Accident/Incident No.

ERA18LA068

Reviewed by NTSB Regional Office

ERA

Name of Investigator

ADAM GERHARDT

Date Report Received

2/4/2018