

# 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

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>Hendersonville</u> State: <u>NC</u><br>ZIP: <u>28793</u> Country: _____<br>Latitude: <u>35-18-27.4200N</u> Longitude: <u>082-25-59.4270W</u><br><i>(Enter in decimal degrees or degrees:minutes:seconds)</i> | <b>Accident/Incident Date/Time</b><br>Date: <u>05-09-2022</u> Local Time: <u>11:am</u><br><i>mm/dd/yyyy</i><br>Time Zone: <u>Eastern</u><br>Collision with Other Aircraft: <input type="radio"/> Midair <input type="radio"/> On-ground <input checked="" type="radio"/> None |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## AIRCRAFT INFORMATION

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Registration Number:</b> <u>N7FJ</u><br><b>Manufacturer:</b> <u>VansRV-6A (ICAIO) 52250142</u><br><b>Model:</b> <u>RV-6-A</u><br><b>Serial Number:</b> <u>22226</u><br><b>Year of Manufacture:</b> <u>1997</u><br><b>Amateur-Built:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No <i>If Yes:</i> <input type="radio"/> Kit/Plans <input type="radio"/> Original Design <b>Make:</b> <u>Vans RV-6-A</u> | <input type="checkbox"/> IFR-Equipped and Certified<br><input type="checkbox"/> Commercial Space Flight<br><input type="checkbox"/> Unmanned Aircraft<br><b>Maximum Gross Weight:</b> <u>1800</u> lbs<br><b>Weight at Time of Accident/Incident:</b> <u>600</u> lbs<br><b>Number of Seats:</b> <u>2</u> <b>Flight Crew Seats:</b> <u>1</u><br><b>Cabin Crew Seats:</b> <u>0</u> <b>Passenger Seats:</b> <u>1</u><br><b>Number of Engines:</b> _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br><i>mm/dd/yyyy</i> | 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 | Lycoming            | O-360A1A            | L-34722-36A                  |                                   | 180                                                                                                  | 1602.8                | n/a                                  | 2000                |
| Eng. 2 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |
| Eng. 3 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |
| Eng. 4 |                     |                     |                              |                                   |                                                                                                      |                       |                                      |                     |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Last Inspection Type</b><br><input type="radio"/> 100-Hour <input type="radio"/> Continuous Airworthiness<br><input type="radio"/> AAIP <input type="radio"/> Conditional Inspection<br><input checked="" type="radio"/> Annual <input type="radio"/> Unknown<br><b>Date Last Inspection:</b> <u>08/05/2022</u><br><i>mm/dd/yyyy</i><br><b>Airframe Total Time:</b> <u>1602.8</u> hrs<br>hours measured at <i>(Select one)</i><br><input type="radio"/> Last Inspection <input checked="" type="radio"/> Time of Accident/Incident | <b>Propeller 1</b><br><input type="radio"/> Fixed Pitch<br><input type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br><b>Manufacturer:</b> _____<br><b>Model:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Propeller 2</b><br><input type="radio"/> Fixed Pitch<br><input type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br><b>Manufacturer:</b> _____<br><b>Model:</b> _____ |
| <b>Type of Maintenance Program (Select one)</b><br><input checked="" type="radio"/> Annual<br><input type="radio"/> Conditional (Amateur-built only)<br><input type="radio"/> Manufacturer's Inspection Program<br><input type="radio"/> Other Approved Inspection Program (AAIP)<br><input type="radio"/> Continuous Airworthiness<br><input type="radio"/> Other, specify: _____                                                                                                                                                    | <b>ELT Installed:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br><i>If Yes:</i><br><b>ELT Manufacturer:</b> _____<br><b>Model or Part No.:</b> _____<br><b>TSO No.:</b> <input type="radio"/> C91 (121.5 MHz) <input type="radio"/> C91a (121.5 MHz)<br><input type="radio"/> C126 (406 MHz)<br><b>Was ELT still mounted in aircraft?</b> <input type="radio"/> Yes <input type="radio"/> No<br><b>Was ELT still connected to antenna?</b> <input type="radio"/> Yes <input type="radio"/> No<br><b>Did ELT Activate?</b> <input type="radio"/> Yes <input type="radio"/> No<br><i>If activated:</i><br><b>Did ELT Aid in Locating Aircraft:</b> <input type="radio"/> Yes <input checked="" type="radio"/> No<br><i>If not activated:</i><br><b>Indicate Reason:</b> <input type="checkbox"/> Impact Damage<br><input type="checkbox"/> Fire Damage<br><input type="checkbox"/> Battery Expired/Damaged<br><input type="checkbox"/> Unknown |                                                                                                                                                                                                     |
| <b>Description of Fire Extinguishing System</b><br><input checked="" type="radio"/> None<br><input type="radio"/> Specify: _____                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Additional Equipment (Check all that apply)</b><br><input checked="" type="checkbox"/> ADS-B<br><input type="checkbox"/> Airframe Parachute<br><input checked="" type="checkbox"/> Angle of Attack Indicator<br><input checked="" type="checkbox"/> Autopilot<br><input type="checkbox"/> Data Recorder<br><input checked="" type="checkbox"/> Electronic Flight Bag or Handheld Device<br><input checked="" type="checkbox"/> Electronic Multifunction Display<br><input checked="" type="checkbox"/> Electronic Primary Flight Display<br><input checked="" type="checkbox"/> Handheld GPS<br><input checked="" type="checkbox"/> Heads Up Display<br><input checked="" type="checkbox"/> Onboard Weather<br><input type="checkbox"/> Satellite Tracking Device<br><input type="checkbox"/> Stall Warning System<br><input type="checkbox"/> Video Recording Device<br><input type="checkbox"/> Other, Specify: _____                                         |                                                                                                                                                                                                     |

**OWNER/OPERATOR INFORMATION****Registered Aircraft Owner**Name: Jesse HarrisCity: HendersonvilleState: ncZIP: 28739Fractional Ownership Aircraft: ☐ Yes ☒ NoCountry: USA**Operator of Aircraft**☒ Same As Registered Owner☐ Same Address as Registered OwnerName: Jesse HarrisCity: Hendersonville

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

State: ncZIP: 28739

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

Country: USA**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: Hendersonville Airport

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

Airport Identifier: 0A7

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

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

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

**Runway Information**Runway ID: 33 (L/R/C) Length: 3075 ft Width: 40 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 ☐ Final ☐ 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" INFORMATION****"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" was pilot flying ☒ Yes ☐ No

**"Flight Crewmember 1" Identification**

First Name: Jesse Harris

City of Residence: Hendersonville

Middle Initial: C

State: SC ZIP: 28739

Last Name: Harris

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

Age at time of Accident/Incident: 55 Date of Birth: 1966 mm/dd/yyyy

Certificate Number:                     

**Degree of Injury**

☐ None ☐ Fatal  
☒ Minor ☐ Unknown  
☐ Serious

**Seat Occupied**

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

**Restraint Type****Available**

☐ None  
☐ Lap only  
☐ 3-point  
☒ 4-point  
☐ 5-point  
☐ Unknown

**Used**

☐ None  
☐ Lap only  
☐ 3-point  
☐ 4-point  
☐ 5-point  
☐ Unknown

**Inflatable Restraints**

☒ Not Installed  
☐ Installed  
☐ Not Deployed  
☐ Deployed  
☐ Unknown

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

☐ None ☐ Flight Instructor ☐ Commercial ☐ US Military  
☐ Private ☐ Recreational ☐ Airline Transport ☐ Foreign  
☐ Student ☐ Sport ☐ Flight Engineer

**Principal Occupation**

☐ Pilot  
☒ Other  
☐ Unknown

**Medical Certificate**

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

**Medical Certificate Validity**

☒ Without limitations/waivers ☐ Unknown  
☐ With limitations/waivers ☐ N/A  
☐ Special Issuance

**Date of Last Medical**

04/07/2021  
mm/dd/yyyy

**Medical Certificate Limitations**

None

**Medical Certificate Special Issuance**

None

**Date of Last Flight Review  
or Equivalent, Including  
FAR 121/135 Checks:** 05-05-2022  
mm/dd/yyyy

**Flight Review Aircraft**

Make: Vans RV-6-A

Model: 6-A

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

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

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

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

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

☒ None  
☐ Airplane  
☐ Helicopter  
☐ Powered Lift

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

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

**Type Ratings**

Single Engine

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

All  
Aircraft

This Make  
& Model

Airplane  
Single  
Engine

Airplane  
Multiengine

Night

Instrument  
Actual Simulated

Rotorcraft

Glider

Lighter  
Than Air

|                        |       |    |       |  |  |  |  |  |  |  |
|------------------------|-------|----|-------|--|--|--|--|--|--|--|
| Total Time             | 2,020 | 25 | 2,020 |  |  |  |  |  |  |  |
| Pilot in Command (PIC) | 2,020 | 25 |       |  |  |  |  |  |  |  |
| Time as Instructor     |       |    |       |  |  |  |  |  |  |  |
| This Make/Model        |       |    |       |  |  |  |  |  |  |  |
| Last 90 Days           | 25    |    |       |  |  |  |  |  |  |  |
| Last 30 Days           |       |    |       |  |  |  |  |  |  |  |
| Last 24 Hours          |       |    |       |  |  |  |  |  |  |  |

| <b>"Flight Crewmember 2" Responsibilities at the Time of Accident/Incident</b><br><input checked="" type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew<br><b>"Flight Crewmember 2" was pilot flying</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------|----------------------------------------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|--|------------|--------|------------------|--------|-----------|------------|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|--|
| <b>"Flight Crewmember 2" Identification</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| First Name: <u>None</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                    | City of Residence: _____                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Middle Initial: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                                                                                                                                                                                                    | State: _____                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ZIP: _____ |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                                                                                                                                                                                                    | Country: _____                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Age at time of Accident/Incident: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                                    | Date of Birth: _____                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       | mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Certificate Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input 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><br><div style="display: flex; justify-content: space-between;"> <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 type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown           </div> </div> |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            | <b>Inflatable Restraints</b><br><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 style="display: grid; grid-template-columns: repeat(4, 1fr); gap: 5px;"> <div><input type="checkbox"/> None</div> <div><input type="checkbox"/> Flight Instructor</div> <div><input type="checkbox"/> Commercial</div> <div><input type="checkbox"/> US Military</div> <div><input type="checkbox"/> Private</div> <div><input type="checkbox"/> Recreational</div> <div><input type="checkbox"/> Airline Transport</div> <div><input type="checkbox"/> Foreign</div> <div><input type="checkbox"/> Student</div> <div><input type="checkbox"/> Sport</div> <div><input type="checkbox"/> Flight Engineer</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <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 type="radio"/> None <input checked="" type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                        |                                                              | <b>Medical Certificate Validity</b><br><input checked="" type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            | <b>Date of Last Medical</b><br>_____<br>mm/dd/yyyy                                                                                                                                                                                            |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Special Issuance</b><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____<br>mm/dd/yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                    | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____ |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s)</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> None<br><input 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 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 type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift                                                                                                                                                                                                                                                                                                                                                                                                     |       | <b>Instructor Rating(s)</b><br><i>(Check all that apply)</i><br><div style="display: flex; justify-content: space-between;"> <div> <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           </div> <div> <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           </div> </div> |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       | <b>Student Endorsements</b> ( <i>Include dates</i> )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">Flight Time (<i>Enter appropriate number of hours in each box</i>)</th> <th rowspan="2">All Aircraft</th> <th rowspan="2">This Make &amp; Model</th> <th rowspan="2">Airplane Single Engine</th> <th rowspan="2">Airplane Multiengine</th> <th rowspan="2">Night</th> <th colspan="2">Instrument</th> <th rowspan="2">Rotorcraft</th> <th rowspan="2">Glider</th> <th rowspan="2">Lighter Than Air</th> </tr> <tr> <th>Actual</th> <th>Simulated</th> </tr> </thead> <tbody> <tr> <td>Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  | Flight Time ( <i>Enter appropriate number of hours in each box</i> ) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time ( <i>Enter appropriate number of hours in each box</i> )                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                                  | Airplane Single Engine                                       | Airplane Multiengine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Night | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |            | Rotorcraft                                                                                                                                                                                                                                    | Glider | Lighter Than Air |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Simulated  |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                                    |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |                                                                                                                                                                                                                                               |        |                  |                                                                      |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

| <b>ADDITIONAL FLIGHT CREWMEMBERS</b> (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                |                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Crew Name and Address</b><br>First Name: <u>None</u> City of Residence: _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                         | <b>Seat Occupied</b><br><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                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Injury</b><br><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; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 50%;"><input type="checkbox"/> Commercial</div> <div style="width: 50%;"><input type="checkbox"/> US Military</div> <div style="width: 50%;"><input type="checkbox"/> Private</div> <div style="width: 50%;"><input type="checkbox"/> Recreational</div> <div style="width: 50%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 50%;"><input type="checkbox"/> Foreign</div> <div style="width: 50%;"><input type="checkbox"/> Student</div> <div style="width: 50%;"><input type="checkbox"/> Sport</div> <div style="width: 50%;"><input type="checkbox"/> Flight Engineer</div> </div> |  |                                                                                                                                                         | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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</b><br><b>Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                         | <b>Total Flight Time at the Time</b><br><b>of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                |                                                                                                                                                                                        |
| <b>Crew Name and Address</b><br>First Name: _____      City of Residence: _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                         | <b>Seat Occupied</b><br><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                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Injury</b><br><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; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 50%;"><input type="checkbox"/> Commercial</div> <div style="width: 50%;"><input type="checkbox"/> US Military</div> <div style="width: 50%;"><input type="checkbox"/> Private</div> <div style="width: 50%;"><input type="checkbox"/> Recreational</div> <div style="width: 50%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 50%;"><input type="checkbox"/> Foreign</div> <div style="width: 50%;"><input type="checkbox"/> Student</div> <div style="width: 50%;"><input type="checkbox"/> Sport</div> <div style="width: 50%;"><input type="checkbox"/> Flight Engineer</div> </div> |  |                                                                                                                                                         | <b>Restraint Type:</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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</b><br><b>Accident/Incident Aircraft?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                         | <b>Total Flight Time at the Time</b><br><b>of this Accident/Incident:</b> _____ hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                |                                                                                                                                                                                        |
| <b>PASSENGER(S) / OTHER PERSONNEL</b> (Include cabin crew; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                |                                                                                                                                                                                        |
| <b>Name and Address</b><br>First Name: _____      City : _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew             <input type="radio"/> Passenger             <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><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>Restraint Type</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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>Age</b><br><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 |
| <b>Name and Address</b><br>First Name: _____      City : _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew             <input type="radio"/> Passenger             <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><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>Restraint Type</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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>Age</b><br><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 |
| <b>Name and Address</b><br>First Name: _____      City : _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew             <input type="radio"/> Passenger             <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><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>Restraint Type</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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>Age</b><br><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 |
| <b>Name and Address</b><br>First Name: _____      City : _____<br>Middle Initial: _____      State: _____      ZIP: _____<br>Last Name: _____      Country: _____<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="radio"/> Crew             <input type="radio"/> Passenger             <input type="radio"/> Other           </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><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>Restraint Type</b><br><div style="display: flex;"> <div style="width: 50%;"> <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="width: 50%;"> <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>Age</b><br><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

## Last Departure Point

Airport ID: K-LKR  
City: Lancaster  
State: SC  
Country: USA

## Time of Departure

Time: 10:00am  
Time Zone: Eastern

## Destination

Airport ID: 0A7  
City: Hendersonville  
State: SC  
Country: 28793

## Type Flight Plan Filed

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

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

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

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

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

## Altitude of In-Flight Occurrence:

Ground        ft msl

# WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE

## Source of Pilot Weather Information

(Check all that apply)

☐ National Weather Service ☐ Company  
☐ Flight Service Station ☐ Military  
☐ TV/Radio ☐ Internet  
☒ Automated Report ☐ None  
☐ Commercial Weather Service (DUATS) ☐ Unknown  
☐ On-Board Weather

## Weather Observation Facility

Facility ID: KAVL  
Observation Time: 10:45  
Time Zone: Eastern  
Distance from Accident Site: 7 nm  
Direction from Accident Site: 180 degrees true

## Basic Conditions

☒ VMC  
☐ IMC  
☐ Unknown

## Light Condition

☐ Dawn ☐ Dusk ☐ Dark Night ☐ Unknown  
☒ Day ☐ Night ☐ Bright Night

## Sky/Lowest Cloud Condition

☒ Clear ☐ Thin Broken  
☐ Few ☐ Thin Overcast  
☐ Partial Obscuration ☐ Unknown  
☐ Scattered

## Ceiling

☒ None (Clear) ☐ Obscured  
☐ Broken ☐ Indefinite  
☐ Overcast ☐ Unknown

Temperature:        (C) or 75 (F)

Dew Point:        (C) or        (F)

Altimeter Setting:        in. Hg  
or        MB

## Lowest Cloud Condition Height

       ft agl

## Ceiling Height

       ft agl

## Wind Direction

☐ Variable

-or-  
Direction:        degrees true

## Wind Speed

☐ Calm  
☒ Light and Variable

-or-  
Speed: 5 kts

## Wind Gusts

☒ Not Gusting

-or-  
Speed: 5 kts

Visibility 25 miles

RVR:        feet

RVV:        miles

Density Altitude:        ft

## Intensity of Precipitation

☐ Light  
☐ Moderate  
☐ Heavy  
☐ N/A  
☐ Unknown

## Type of Precipitation (Check all that apply)

☒ None ☐ Drizzle ☐ Freezing Rain  
☐ Rain ☐ Ice Pellets ☐ Snow Shower  
☐ Snow ☐ Snow Pellets ☐ Ice Pellets Shower  
☐ Hail ☐ Snow Grains ☐ Freezing Drizzle  
☐ Rain Showers ☐ Ice Crystals

## Restriction to Visibility (Check all that apply)

☒ None ☐ Fog  
☐ Blowing Dust ☐ Ground Fog  
☐ Blowing Sand ☐ Haze  
☐ Blowing Snow ☐ Ice Fog  
☐ Blowing Spray ☐ Smoke  
☐ Dust ☐ Unknown

## Icing Forecast

Amount Type  
☒ None ☐ N/A  
☐ Trace ☐ Rime  
☐ Light ☐ Clear  
☐ Moderate ☐ Mixed  
☐ Severe ☐ Unknown  
☐ Unknown

## Icing Actual

Amount Type  
☒ None ☐ N/A  
☐ Trace ☐ Rime  
☐ Light ☐ Clear  
☐ Moderate ☐ Mixed  
☐ Severe ☐ Unknown  
☐ Unknown

## Turbulence

Type (Check all that apply) Severity  
☒ None ☐ Light  
☐ Clear Air ☐ Moderate  
☐ Terrain-Induced ☐ Severe  
☐ Convective Turbulence ☐ Extreme

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

Displaced Threshold

## 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)*

The following is an abbreviated description of damage: Nose Gear Bent, Propeller hub, canopy frame Bent, front glass, canopy glass, Left Wing, Horizontal stabilizer, vertical stabilizer, elevator Rudder, Dents and multiple crinkles throughout fuselage and multiple structural component of Aircraft. The Aircraft has been meticulously maintained.

## 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.

- 1) Completed Pre-Landing Checklist. Situation seemed good to go. Was 20' above Runway Felt slight Tail wind.
- 2) At this point I should have gone around but felt like Landing was salvageable.
- 3) hard landing. Bounced felt like prop hit, So I did not want to try a go around.
- 4) Aircraft Bounced again, Steered Aircraft onto Grass and Propeller Hit again and Aircraft Flipped Forward.
- 5) I immediately went over Emergency Shut down Procedure. Turned off fuel, Master Switch, etc..

I am embarrassed and ashamed.

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

Operator/Owner Safety Recommendation

I shuld have aborted landing and gone around.

**MECHANICAL MALFUNCTION/FAILURE** (If more space is needed, continue on separate sheet)Was there Mechanical Malfunction/Failure? ☐ Yes ☒ No

(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)

Total Time/Cycles  
On Part

\_\_\_\_\_ Hours

\_\_\_\_\_ Cycles

Time Since This Part  
Inspected/Overhauled

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**

Fuel on Board at Last Takeoff

(Convert from pounds, as necessary)

30 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

Just me. I got out of Aircraft ASAP after performing Emergency shut down Procedures. Master Switch off. Fule off.

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

Aircraft Registration Number

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.

Please call me at: [REDACTED] if more information is needed.

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

Date of this Report

5/31-2022

mm/dd/yyyy

Name of Pilot/Operator: Jesse Harris

Signature: [REDACTED]

-- 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.

ERA22LA232

Reviewed by NTSB Regional Office

ERA

Name of Investigator

GERHARDT, ADAM

Date Report Received

5/31/2022