

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

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

## BASIC INFORMATION

### Accident/Incident Location

Nearest City/Place: Spanish Fork State: Utah

ZIP: 84660 Country: USA

Latitude: 40.1450278 Longitude: -111.6676944

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

### Accident/Incident Date/Time

Date: 08/09/2018 Local Time: 11:30 AM

mm/dd/yyyy

Time Zone: Mountain

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

## AIRCRAFT INFORMATION

Registration Number: N557AT

Manufacturer: Trendak

Model: Tercel

Serial Number: T&S F26817S

Year of Manufacture: 2017

Amateur-Built: ☒ Yes If Yes: ☒ Kit/Plans Make: Aviation Artur Trendak

☐ No

☐ Original Design

☐ IFR-Equipped and Certified

☐ Commercial Space Flight

☐ Unmanned Aircraft

Maximum Gross Weight: 1320 lbs

Weight at Time of Accident/Incident: 892 lbs

Number of Seats: 2 Flight Crew Seats: \_\_\_\_\_

Cabin Crew Seats: \_\_\_\_\_ Passenger Seats: 1

Number of Engines: 1

### Category of Aircraft

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

### Type of Airworthiness Certificate

(Check all that apply)

#### Standard

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

#### Special

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

☐ Certificate of Authorization or Waiver (COA)

☐ None

☐ Unknown

### Landing Gear

(Check all that apply)

☐ Retractable

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

### Engine Type (Select one)

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

### Fuel System Type (Reciprocating)

- ☒ Carburetor
- ☐ Fuel-Injected

| Engine | Engine Manufacturer | Engine Model/Series | Manufacturer's Serial Number | Date of Mfg.<br>mm/dd/yyyy | Rated Power<br><input checked="" type="radio"/> Horsepower or<br><input type="radio"/> lbs of Thrust | Total Time<br>(hours) | Time Since:<br>Inspection<br>(hours) | Overhaul<br>(hours) |
|--------|---------------------|---------------------|------------------------------|----------------------------|------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------|
| Eng. 1 | Rotax               | 912 with AAT Turbo  | #9580148                     | 2017                       | 135 HP                                                                                               | 90.4                  | 28.2                                 |                     |
| Eng. 2 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 3 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |
| Eng. 4 |                     |                     |                              |                            |                                                                                                      |                       |                                      |                     |

### Last Inspection Type

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

Date Last Inspection: 06/21/2018  
mm/dd/yyyy

Airframe Total Time: 189 hrs

hours measured at (Select one)

- ☐ Last Inspection
- ☒ Time of Accident/Incident

### Type of Maintenance Program (Select one)

- ☐ Annual
- ☐ Conditional (Amateur-built only)
- ☐ Manufacturer's Inspection Program
- ☐ Other Approved Inspection Program (AAIP)
- ☐ Continuous Airworthiness
- ☒ Other, specify: Annual plus 100/50/25 hr

### Description of Fire Extinguishing System

- ☒ None
- ☐ Specify:

### Propeller 1

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

Manufacturer: Kaspar

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

### Propeller 2

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

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

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

ELT Installed: ☐ Yes ☒ No

If Yes:

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

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

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

Was ELT still mounted in aircraft? ☐ Yes ☐ No

Was ELT still connected to antenna? ☐ Yes ☐ No

Did ELT Activate? ☐ Yes ☐ No

If activated:

Did ELT Aid in Locating Aircraft? ☐ Yes ☐ No

If not activated:

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

### Additional Equipment (Check all that apply)

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

**OWNER/OPERATOR INFORMATION****Registered Aircraft Owner**Name: Airgyro Aviation, Josh HumphreysCity: Spanish ForkState: UtahZIP: 84660Fractional Ownership Aircraft: ☐ Yes ☐ NoCountry: USA**Operator of Aircraft**☐ Same As Registered Owner☐ Same Address as Registered OwnerName: Josh HumphreysCity: Spanish ForkDoing Business As: Airgyro AviationState: UtahZIP: 84660

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: Spanish Fork Airport Springville-Woodhouse FieldDistance From Airport Center: 0 smAirport Identifier: KSPKDirection From Airport: None degrees trueProximity to Airport: ☐ Off Airport/Airstrip ☒ On Airport/Airstrip ☐ N/AAirport Elevation: 4529.5 ft. msl**Runway Information**Runway ID: 30 (L/R/C) Length: 6500 ft Width: 100 ft**Runway/Landing Surface (Check all that apply)**

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

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

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

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

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

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

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

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

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

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

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

### “Flight Crewmember 1” Identification

First Name: Duane

City of Residence: Provo

Middle Initial: E

State: Utah ZIP: 84604

Last Name: Ruffner

Country: USA

Age at time of Accident/Incident: 59 Date of Birth:                      *mm/dd/yyyy*

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input checked="" type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                                   |  | <b>Seat Occupied</b><br><input checked="" type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single              |  | <b>Restraint Type</b><br><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> |  | <b>Inflatable Restraints</b><br><input checked="" type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><div> <input type="checkbox"/> None      <input type="checkbox"/> Flight Instructor      <input type="checkbox"/> Commercial      <input type="checkbox"/> US Military<br/> <input type="checkbox"/> Private      <input type="checkbox"/> Recreational      <input type="checkbox"/> Airline Transport      <input type="checkbox"/> Foreign<br/> <input checked="" type="checkbox"/> Student      <input type="checkbox"/> Sport      <input type="checkbox"/> Flight Engineer         </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 type="radio"/> Class 3<br><input type="radio"/> Class 1 <input checked="" 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><hr/> <i>mm/dd/yyyy</i>                                                                                                                                                                                    |

None

Unrestricted driver's license, for operation as a Sport Pilot

|                                                                                                           |                                                                            |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____<br><i>mm/dd/yyyy</i> | <b>Flight Review Aircraft</b><br><b>Make:</b> _____<br><b>Model:</b> _____ |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|

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

|                                          |                                                                                                                  |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| <b>Type Ratings</b><br><br>Student Pilot | <b>Student Endorsements</b> <i>(Include dates)</i><br><br>Presolo knowledge exam and Solo endorsement, 8/8/2018. |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------|

| <b>Flight Time</b> <i>(Enter appropriate number of hours in each box)</i> | <b>All Aircraft</b> | <b>This Make &amp; Model</b> | <b>Airplane Single Engine</b> | <b>Airplane Multiengine</b> | <b>Night</b> | <b>Instrument</b> |                  | <b>Rotorcraft</b> | <b>Glider</b> | <b>Lighter Than Air</b> |
|---------------------------------------------------------------------------|---------------------|------------------------------|-------------------------------|-----------------------------|--------------|-------------------|------------------|-------------------|---------------|-------------------------|
|                                                                           |                     |                              |                               |                             |              | <b>Actual</b>     | <b>Simulated</b> |                   |               |                         |
| Total Time                                                                | 27                  | 10                           | 8                             |                             |              |                   |                  | 16                |               |                         |
| Pilot in Command (PIC)                                                    |                     |                              |                               |                             |              |                   |                  |                   |               |                         |
| Time as Instructor                                                        |                     |                              |                               |                             |              |                   |                  |                   |               |                         |
| This Make/Model                                                           |                     |                              |                               |                             |              |                   |                  |                   |               |                         |
| Last 90 Days                                                              | 10                  | 10                           |                               |                             |              |                   |                  | 10                |               |                         |
| Last 30 Days                                                              | 7                   | 7                            |                               |                             |              |                   |                  | 7                 |               |                         |
| Last 24 Hours                                                             | 1                   | 1                            |                               |                             |              |                   |                  | 1                 |               |                         |

## "FLIGHT CREWMEMBER 2" INFORMATION

### "Flight Crewmember 2" Responsibilities at the Time of Accident/Incident

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

"Flight Crewmember 2" was pilot flying   ☐ Yes   ☐ No

### "Flight Crewmember 2" Identification

First Name: \_\_\_\_\_ City of Residence: \_\_\_\_\_  
 Middle Initial: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Country: \_\_\_\_\_  
 Age at time of Accident/Incident: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ mm/dd/yyyy  
 Certificate Number: \_\_\_\_\_

| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input checked="" type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Seat Occupied</b><br><input checked="" type="radio"/> Left <input type="radio"/> Front <input type="radio"/> Unknown<br><input type="radio"/> Right <input type="radio"/> Rear<br><input type="radio"/> Center <input type="radio"/> Single                                                                                                                                     | <b>Restraint Type</b><br><table style="width: 100%;"> <tr> <th style="text-align: left;">Available</th> <th style="text-align: left;">Used</th> </tr> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> None</td> </tr> <tr> <td><input type="radio"/> Lap only</td> <td><input type="radio"/> Lap only</td> </tr> <tr> <td><input type="radio"/> 3-point</td> <td><input type="radio"/> 3-point</td> </tr> <tr> <td><input checked="" type="radio"/> 4-point</td> <td><input type="radio"/> 4-point</td> </tr> <tr> <td><input type="radio"/> 5-point</td> <td><input type="radio"/> 5-point</td> </tr> <tr> <td><input type="radio"/> Unknown</td> <td><input type="radio"/> Unknown</td> </tr> </table> | Available                                  | Used                                | <input type="radio"/> None           | <input type="radio"/> None                                           | <input type="radio"/> Lap only        | <input type="radio"/> Lap only             | <input type="radio"/> 3-point                   | <input type="radio"/> 3-point    | <input checked="" type="radio"/> 4-point  | <input type="radio"/> 4-point            | <input type="radio"/> 5-point | <input type="radio"/> 5-point                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> Unknown | <input type="radio"/> Unknown                     | <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 |                                                |                           |                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------|--------------------------------------|----------------------------------------------------------------------|---------------------------------------|--------------------------------------------|-------------------------------------------------|----------------------------------|-------------------------------------------|------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------|----------------------------------------|--|
| Available                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Used                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> None                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Lap only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> Lap only                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> 3-point                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> 3-point                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input checked="" type="radio"/> 4-point                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="radio"/> 4-point                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> 5-point                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> 5-point                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <b>Pilot Certificate(s)</b> <i>(Check all that apply)</i><br><table style="width: 100%;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> Flight Instructor</td> <td><input type="checkbox"/> Commercial</td> <td><input type="checkbox"/> US Military</td> </tr> <tr> <td><input type="checkbox"/> Private</td> <td><input type="checkbox"/> Recreational</td> <td><input type="checkbox"/> Airline Transport</td> <td><input type="checkbox"/> Foreign</td> </tr> <tr> <td><input type="checkbox"/> Student</td> <td><input checked="" type="checkbox"/> Sport</td> <td><input type="checkbox"/> Flight Engineer</td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Flight Instructor | <input type="checkbox"/> Commercial | <input type="checkbox"/> US Military | <input type="checkbox"/> Private                                     | <input type="checkbox"/> Recreational | <input type="checkbox"/> Airline Transport | <input type="checkbox"/> Foreign                | <input type="checkbox"/> Student | <input checked="" type="checkbox"/> Sport | <input type="checkbox"/> Flight Engineer |                               | <b>Medical Certificate Validity</b><br><table style="width: 100%;"> <tr> <td><input type="radio"/> Without limitations/waivers</td> <td><input type="radio"/> Unknown</td> </tr> <tr> <td><input type="radio"/> With limitations/waivers</td> <td><input type="radio"/> N/A</td> </tr> <tr> <td><input type="radio"/> Special Issuance</td> <td></td> </tr> </table> |                               | <input type="radio"/> Without limitations/waivers | <input type="radio"/> Unknown                                                                                                                                                                                                  | <input type="radio"/> With limitations/waivers | <input type="radio"/> N/A | <input type="radio"/> Special Issuance |  |
| <input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Flight Instructor                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Commercial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> US Military       |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="checkbox"/> Private                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Recreational                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Airline Transport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Foreign           |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="checkbox"/> Student                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input checked="" type="checkbox"/> Sport                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Flight Engineer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Without limitations/waivers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> With limitations/waivers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> N/A                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Special Issuance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <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><table style="width: 100%;"> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> Class 3</td> </tr> <tr> <td><input type="radio"/> Class 1</td> <td><input checked="" type="radio"/> Driver's License (Sport Pilot only)</td> </tr> <tr> <td><input type="radio"/> Class 2</td> <td><input type="radio"/> Unknown</td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> None                 | <input type="radio"/> Class 3       | <input type="radio"/> Class 1        | <input checked="" type="radio"/> Driver's License (Sport Pilot only) | <input type="radio"/> Class 2         | <input type="radio"/> Unknown              | <b>Date of Last Medical</b><br>_____ mm/dd/yyyy |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Class 3                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Class 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="radio"/> Driver's License (Sport Pilot only)                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |
| <input type="radio"/> Class 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                     |                                      |                                                                      |                                       |                                            |                                                 |                                  |                                           |                                          |                               |                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                   |                                                                                                                                                                                                                                |                                                |                           |                                        |  |

### Medical Certificate Limitations

### Medical Certificate Special Issuance

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

### Flight Review Aircraft

**Make:** \_\_\_\_\_  
**Model:** \_\_\_\_\_

|                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                   |                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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><table style="width: 100%;"> <tr> <td> <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                         </td> <td> <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                         </td> </tr> </table> | <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 | <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 |
| <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                                                                 | <input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport                                                                                                                         |                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                   |                                                                                                                                                                                                            |

### Type Ratings

### Student Endorsements *(Include dates)*

| 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                                                      |              |                   |                        |                      |       |            |           |            |        |                  |

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

## FLIGHT ITINERARY INFORMATION

|                                                                                                                                  |                                                                              |                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Last Departure Point</b><br>Airport ID: <u>KSPK</u><br>City: <u>Spanish Fork</u><br>State: <u>Utah</u><br>Country: <u>USA</u> | <b>Time of Departure</b><br>Time: <u>11:30</u><br>Time Zone: <u>Mountain</u> | <b>Destination</b><br>Airport ID: <u>KSPK</u><br>City: <u>Spanish Fork</u><br>State: <u>Utah</u><br>Country: <u>USA</u> | <b>Type Flight Plan Filed</b><br><input checked="" type="radio"/> None <input type="radio"/> VFR/IFR<br><input type="radio"/> Company VFR <input type="radio"/> IFR<br><input type="radio"/> Military VFR <input type="radio"/> Unknown<br><input type="radio"/> VFR<br><b>Activated?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

|                                                                             |                                          |                                                         |                                                                  |
|-----------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------|
| <b>Airspace where the accident/incident occurred</b> (Check all that apply) |                                          |                                                         | <b>Altitude of In-Flight Occurrence:</b><br><u>4529.5</u> ft msl |
| <input type="checkbox"/> Class A                                            | <input type="checkbox"/> Class G         | <input type="checkbox"/> Military Operations Area (MOA) | <input type="checkbox"/> Special                                 |
| <input type="checkbox"/> Class B                                            | <input type="checkbox"/> Demo Area       | <input type="checkbox"/> Airport Advisory Area          | <input type="checkbox"/> Air Traffic Control Area                |
| <input type="checkbox"/> Class C                                            | <input type="checkbox"/> Warning Area    | <input type="checkbox"/> Jet Training Area              | <input type="checkbox"/> Unknown                                 |
| <input checked="" type="checkbox"/> Class D                                 | <input type="checkbox"/> Prohibited Area | <input type="checkbox"/> TRSA                           |                                                                  |
| <input type="checkbox"/> Class E                                            | <input type="checkbox"/> Restricted Area | <input type="checkbox"/> FAR 93                         |                                                                  |

## WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE

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

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

|                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                 |                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sky/Lowest Cloud Condition</b><br><input checked="" type="radio"/> Clear <input type="radio"/> Thin Broken<br><input type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input type="radio"/> Unknown<br><input type="radio"/> Scattered | <b>Ceiling</b><br><input checked="" type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input type="radio"/> Broken <input type="radio"/> Indefinite<br><input type="radio"/> Overcast <input type="radio"/> Unknown | <b>Temperature:</b> _____ (C) or <u>-80</u> (F)<br><b>Dew Point:</b> _____ (C) or _____ (F)<br><b>Altimeter Setting:</b> _____ in. Hg<br>or _____ MB |
| <b>Lowest Cloud Condition Height</b><br>_____ ft agl                                                                                                                                                                                                                                         | <b>Ceiling Height</b><br>_____ ft agl                                                                                                                                                                                           |                                                                                                                                                      |

|                                                                                                           |                                                                                                                                   |                                                                                                  |                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Wind Direction</b><br><input type="checkbox"/> Variable<br>-or-<br>Direction: <u>~300</u> degrees true | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>-or-<br>Speed: <u>~5</u> kts | <b>Wind Gusts</b><br><input checked="" type="checkbox"/> Not Gusting<br>-or-<br>Speed: _____ kts | <b>Visibility</b> <u>&gt;10</u> miles<br>RVR: _____ feet<br>RVV: _____ miles<br><b>Density Altitude:</b> _____ ft |
|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|

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

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

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

None

**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)*

Broken propeller; rotor detached; one of the two tail booms severely bent; tail severely damaged; severe damage to cabin, cabin windows and doors.

Photos of wreckage attached.

**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.

See attached document.

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

Operator/Owner Safety Recommendation

See attached documents.

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

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

**Total Time/Cycles  
On Part**

\_\_\_\_\_ Hours

\_\_\_\_\_ Cycles

**Time Since This Part  
Inspected/Overhauled**

\_\_\_\_\_ Hours

**FUEL & SERVICES INFORMATION**

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

~10-15 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**

Checked oil and other fluids. All OK.

**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

When the aircraft came to a stop it was lying on it's left side. I unbuckled my harness and stood up on the inside of the left door and climbed out through the open right side door.

**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.

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

Date of this Report

08/22/2018

*mm/dd/yyyy*

Name of Pilot/Operator: Duane Ruffner

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

-- or --

☐

Check here to electronically sign this document

If a Person Other than Pilot/Operator is Filing Report

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

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

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

-- or --

☐

Check here to electronically sign this document

**FOR NTSB USE ONLY**

NTSB Accident/Incident No.

GAA18CA484

Reviewed by NTSB Regional Office

GAA

Name of Investigator

Kathryn Benhoff

Date Report Received

8/24/2018