

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

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

**BASIC INFORMATION**

|                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                           |  |
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| <b>Accident/Incident Location</b><br>Nearest City/Place: <u>CARPINTERIA</u> State: <u>CA</u><br>ZIP: _____ Country: <u>USA</u><br>Latitude: <u>34.26.50N</u> Longitude: <u>119.26.58W</u><br><i>(Enter in decimal degrees or degrees:minutes:seconds)</i> |  | <b>Accident/Incident Date/Time</b><br>Date: <u>06/10/2017</u> Local Time: <u>1430</u><br><i>mm/dd/yyyy</i> Time Zone: <u>PACIFIC</u><br>Collision with Other Aircraft: <input type="radio"/> Midair <input type="radio"/> On-ground <input checked="" type="radio"/> None |  |
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**AIRCRAFT INFORMATION**

|                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
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| Registration Number: <u>N2171D</u><br>Manufacturer: <u>PIPER</u><br>Model: <u>PA 28 141</u><br>Serial Number: <u>28 7916146</u><br>Year of Manufacture: <u>1978</u><br>Amateur-Built: <input type="radio"/> Yes <input checked="" type="radio"/> No If Yes: <input type="radio"/> Kit/Plans <input type="radio"/> Original Design Make: _____ |  | <input checked="" type="checkbox"/> IFR-Equipped and Certified<br><input type="checkbox"/> Commercial Space Flight<br><input type="checkbox"/> Unmanned Aircraft<br>Maximum Gross Weight: <u>2440</u> lbs<br>Weight at Time of Accident/Incident: <u>unknown</u> lbs<br>Number of Seats: <u>4</u> Flight Crew Seats: <u>2</u><br>Cabin Crew Seats: <u>0</u> Passenger Seats: <u>2</u><br>Number of Engines: <u>1</u> |  |
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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|--------------------------------------------|-------------------------------------|------------------------------------|----------------------------------|----------------------------------|--------------------------------------|-----------------------------------|-----------------------------------------|------------------------------------|---------------------------------------|----------------------------------|----------------------------------------------|--|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Category of Aircraft</b><br><input checked="" type="radio"/> Airplane<br><input type="radio"/> Balloon<br><input type="radio"/> Blimp/Dirigible<br><input type="radio"/> Glider<br><input type="radio"/> Gyroplane<br><input type="radio"/> Helicopter<br><input type="radio"/> Powered Lift<br><input type="radio"/> Rocket<br><input type="radio"/> Ultralight<br><input type="radio"/> Unknown | <b>Type of Airworthiness Certificate</b><br><i>(Check all that apply)</i><br><table border="0"> <tr> <td><b>Standard</b></td> <td><b>Special</b></td> </tr> <tr> <td><input checked="" type="checkbox"/> Normal</td> <td><input type="checkbox"/> Restricted</td> </tr> <tr> <td><input type="checkbox"/> Aerobatic</td> <td><input type="checkbox"/> Limited</td> </tr> <tr> <td><input type="checkbox"/> Balloon</td> <td><input type="checkbox"/> Provisional</td> </tr> <tr> <td><input type="checkbox"/> Commuter</td> <td><input type="checkbox"/> Special Flight</td> </tr> <tr> <td><input type="checkbox"/> Transport</td> <td><input type="checkbox"/> Experimental</td> </tr> <tr> <td><input type="checkbox"/> Utility</td> <td><input type="checkbox"/> Special Light-Sport</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Experimental Light-Sport</td> </tr> </table> <input type="checkbox"/> Certificate of Authorization or Waiver (COA)<br><input type="checkbox"/> None <input type="checkbox"/> Unknown | <b>Standard</b> | <b>Special</b> | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Restricted | <input type="checkbox"/> Aerobatic | <input type="checkbox"/> Limited | <input type="checkbox"/> Balloon | <input type="checkbox"/> Provisional | <input type="checkbox"/> Commuter | <input type="checkbox"/> Special Flight | <input type="checkbox"/> Transport | <input type="checkbox"/> Experimental | <input type="checkbox"/> Utility | <input type="checkbox"/> Special Light-Sport |  | <input type="checkbox"/> Experimental Light-Sport | <b>Landing Gear</b><br><i>(Check all that apply)</i><br><input type="checkbox"/> Retractable<br><input checked="" type="checkbox"/> Tricycle <input type="checkbox"/> Tailwheel<br><input type="checkbox"/> Amphibian <input type="checkbox"/> High Skid<br><input type="checkbox"/> Emergency Float <input type="checkbox"/> Skid<br><input type="checkbox"/> Float <input type="checkbox"/> Ski<br><input type="checkbox"/> Hull <input type="checkbox"/> Ski/Wheel<br><input type="checkbox"/> Other Launch/Recovery System<br><input type="checkbox"/> None <input type="checkbox"/> Unknown | <b>Engine Type (Select one)</b><br><input checked="" type="radio"/> Reciprocating <input type="radio"/> Liquid Rocket<br><input type="radio"/> Turbo Shaft <input type="radio"/> Solid Rocket<br><input type="radio"/> Turbo Prop <input type="radio"/> Hybrid Rocket<br><input type="radio"/> Turbo Jet <input type="radio"/> None<br><input type="radio"/> Turbo Fan <input type="radio"/> Unknown<br><input type="radio"/> Electric<br><b>Fuel System Type (Reciprocating)</b><br><input checked="" type="radio"/> Carburetor <input type="radio"/> Fuel-Injected |
| <b>Standard</b>                                                                                                                                                                                                                                                                                                                                                                                      | <b>Special</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input checked="" type="checkbox"/> Normal                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Restricted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Aerobatic                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Limited                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Balloon                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Provisional                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Commuter                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Special Flight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Transport                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Experimental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Utility                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Special Light-Sport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Experimental Light-Sport                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 |                |                                            |                                     |                                    |                                  |                                  |                                      |                                   |                                         |                                    |                                       |                                  |                                              |  |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| Engine | Engine Manufacturer | Engine Model/Serial | Manufacturer's Serial Number | Date of Mfg. <i>mm/dd/yyyy</i> | Rated Power <input checked="" type="radio"/> Horsepower or <input type="radio"/> lbs of Thrust | Total Time (hours) | Time Since: Inspection (hours) Overhaul (hours) |
|--------|---------------------|---------------------|------------------------------|--------------------------------|------------------------------------------------------------------------------------------------|--------------------|-------------------------------------------------|
| Eng. 1 | LYCOMING            | O-320-D36           | L-8641-39A                   | 10/01/1978                     | 160                                                                                            | 9797.2             | 35.4 234.4                                      |
| Eng. 2 |                     |                     |                              |                                |                                                                                                |                    |                                                 |
| Eng. 3 |                     |                     |                              |                                |                                                                                                |                    |                                                 |
| Eng. 4 |                     |                     |                              |                                |                                                                                                |                    |                                                 |

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| <b>Last Inspection Type</b><br><input type="radio"/> 100-Hour <input type="radio"/> Continuous Airworthiness<br><input type="radio"/> AAIP <input type="radio"/> Conditional Inspection<br><input checked="" type="radio"/> Annual <input type="radio"/> Unknown<br>Date Last Inspection: <u>06/06/2017</u><br><i>mm/dd/yyyy</i><br>Airframe Total Time: <u>15034</u> hrs<br>hours measured at (Select one)<br><input checked="" type="radio"/> Last Inspection <input type="radio"/> Time of Accident/Incident | <b>Propeller 1</b><br><input checked="" type="radio"/> Fixed Pitch <input type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br>Manufacturer: <u>SEN SENICH</u><br>Model: <u>74 DM6-0-60</u><br><b>Propeller 2</b><br><input type="radio"/> Fixed Pitch <input type="radio"/> Controllable Pitch<br><input type="radio"/> Ground Adjustable<br>Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Type of Maintenance Program (Select one)</b><br><input checked="" type="radio"/> Annual<br><input type="radio"/> Conditional (Amateur-built only)<br><input type="radio"/> Manufacturer's Inspection Program<br><input type="radio"/> Other Approved Inspection Program (AAIP)<br><input type="radio"/> Continuous Airworthiness<br><input type="radio"/> Other, specify: _____                                                                                                                              | <b>ELT Installed:</b> <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If Yes:<br>ELT Manufacturer: <u>AMERI-KING</u><br>Model or Part No.: <u>AK 450</u><br>TSO No.: <input type="radio"/> C91 (121.5 MHz) <input checked="" type="radio"/> C91a (121.5 MHz)<br><input type="radio"/> C126 (406 MHz)<br>Was ELT still mounted in aircraft? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>Was ELT still connected to antenna? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>Did ELT Activate? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If activated:<br>Did ELT Aid in Locating Aircraft? <input checked="" type="radio"/> Yes <input type="radio"/> No<br>If not activated:<br>Indicate Reason: <input type="checkbox"/> Impact Damage <input type="checkbox"/> Fire Damage<br><input type="checkbox"/> Battery Expired/Damaged <input type="checkbox"/> Unknown |
| <b>Description of Fire Extinguishing System</b><br><input checked="" type="radio"/> None <input type="radio"/> Specify: _____                                                                                                                                                                                                                                                                                                                                                                                   | <b>Additional Equipment (Check all that apply)</b><br><input type="checkbox"/> ADS-B<br><input type="checkbox"/> Airframe Parachute<br><input type="checkbox"/> Angle of Attack Indicator<br><input type="checkbox"/> Autopilot<br><input type="checkbox"/> Data Recorder<br><input type="checkbox"/> Electronic Flight Bag or Handheld Device<br><input type="checkbox"/> Electronic Multifunction Display<br><input type="checkbox"/> Electronic Primary Flight Display<br><input type="checkbox"/> Handheld GPS<br><input type="checkbox"/> Heads Up Display<br><input type="checkbox"/> Onboard Weather<br><input type="checkbox"/> Satellite Tracking Device<br><input checked="" type="checkbox"/> Stall Warning System<br><input type="checkbox"/> Video Recording Device<br><input type="checkbox"/> Other, Specify: _____                                                                                                              |

| OWNER/OPERATOR INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
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| Registered Aircraft Owner<br>Name: <u>NATIONAL AIR COLLEGE INTERNATIONAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | City: <u>SAN DIEGO</u><br>State: <u>CA</u> ZIP: <u>92123</u><br>Country: <u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| Fractional Ownership Aircraft: <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| Operator of Aircraft <input checked="" type="checkbox"/> Same As Registered Owner<br>Name: _____<br>Doing Business As: _____<br>Air Carrier/Operator Designator (4 Character Code): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input checked="" type="checkbox"/> Same Address as Registered Owner<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>Operating Certificates Held</b><br><i>(Check all that apply)</i><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Flag Carrier Operating Certificate (FAR 121)<br><input type="checkbox"/> Supplemental<br><input type="checkbox"/> Air Cargo<br><input type="checkbox"/> Foreign Air Carriers (FAR 129)<br><input type="checkbox"/> Rotorcraft External Load (FAR 133)<br><input type="checkbox"/> Commuter Air Carrier (FAR 135)<br><input type="checkbox"/> On-Demand Air Taxi (FAR 135)<br><input type="checkbox"/> Commercial Air Tour (FAR 136)<br><input type="checkbox"/> Agricultural Aircraft (FAR 137)<br><input type="checkbox"/> Pilot School (FAR 141)<br><input type="checkbox"/> Certificate of Authorization or Waiver (C/A)<br><input type="checkbox"/> Commercial Space Transportation<br>Experimental Permit<br><input type="checkbox"/> Commercial Space Transportation License<br><input type="checkbox"/> Other Operator of Large Aircraft                                                                          | <b>Regulation Flight Conducted Under</b><br><input checked="" type="radio"/> FAR 91 <input type="radio"/> FAR 129 <input type="radio"/> FAR 415<br><input type="radio"/> FAR 103 <input type="radio"/> FAR 133 <input type="radio"/> FAR 431<br><input type="radio"/> FAR 121 <input type="radio"/> FAR 135 <input type="radio"/> FAR 435<br><input type="radio"/> FAR 125 <input type="radio"/> FAR 137 <input type="radio"/> FAR 437<br><br><input type="radio"/> FAR 91 Special Flight<br><input type="radio"/> Non-US, Commercial<br><input type="radio"/> Non-US, Non-commercial<br><br><input type="radio"/> Public Aircraft <i>(Select one)</i><br><input type="radio"/> Armed Forces<br><input type="radio"/> Federal<br><input type="radio"/> State<br><input type="radio"/> Local<br><input type="radio"/> Unknown | <b>Revenue Operation for FAR 121, 125, 129, 135</b><br><i>(Select one for each group)</i><br><br><div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Scheduled or Commuter<br/> <input type="radio"/> Non-Scheduled or Air Taxi         </div> <div> <input type="radio"/> Domestic<br/> <input type="radio"/> International         </div> </div><br><input type="radio"/> Passenger<br><input type="radio"/> Cargo<br><input type="radio"/> Mail Contract Only                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>Revenue Sightseeing Flight</b><br><input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Purpose of Flight for FAR 91, 103, 133, 137</b><br><i>(Select one)</i><br><div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Aerial Application<br/> <input type="radio"/> Aerial Observation<br/> <input type="radio"/> Air Drop<br/> <input type="radio"/> Air Race/Show<br/> <input type="radio"/> Banner Tow<br/> <input type="radio"/> Business<br/> <input type="radio"/> Executive/Corporate<br/> <input type="radio"/> External Load<br/> <input type="radio"/> Ferry         </div> <div> <input type="radio"/> Firefighting<br/> <input type="radio"/> Flight Test<br/> <input type="radio"/> Glider Tow<br/> <input type="radio"/> Instructional<br/> <input type="radio"/> Other Work Use<br/> <input checked="" type="radio"/> Personal<br/> <input type="radio"/> Positioning<br/> <input type="radio"/> Skydiving         </div> <div> <input type="radio"/> Unknown         </div> </div>  |  |
| <b>AIRPORT INFORMATION</b> <i>(Fill in if accident/incident occurred on approach, landing, takeoff, departure, or within 3 miles of an airport)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| Airport Name: _____<br>Airport Identifier: _____<br>Proximity to Airport: <input type="radio"/> Off Airport/Airstrip <input type="radio"/> On Airport/Airstrip <input type="radio"/> N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Distance From Airport Center: _____ sm<br>Direction From Airport: _____ degrees true<br>Airport Elevation: _____ ft. msl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| <b>Runway Information</b><br>Runway ID: _____ (L/R/C) Length: _____ ft Width: _____ ft                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Condition of Runway/Landing Surface</b> <i>(Check all that apply)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Dry<br/> <input type="checkbox"/> Holes<br/> <input type="checkbox"/> Ice Covered<br/> <input type="checkbox"/> Rough<br/> <input type="checkbox"/> Rubber Deposits<br/> <input type="checkbox"/> Slush-Covered         </div> <div style="width: 33%;"> <input type="checkbox"/> Snow-Compacted<br/> <input type="checkbox"/> Snow-Crusted<br/> <input type="checkbox"/> Snow-Dry<br/> <input type="checkbox"/> Snow-Wet<br/> <input type="checkbox"/> Soft<br/> <input type="checkbox"/> Vegetation         </div> <div style="width: 33%;"> <input type="checkbox"/> Water-Calm<br/> <input type="checkbox"/> Water-Choppy<br/> <input type="checkbox"/> Water-Glassy<br/> <input type="checkbox"/> Wet<br/> <input type="checkbox"/> Unknown         </div> </div> |  |
| <b>Runway/Landing Surface</b> <i>(Check all that apply)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> Asphalt<br/> <input type="checkbox"/> Concrete<br/> <input type="checkbox"/> Dirt         </div> <div style="width: 25%;"> <input type="checkbox"/> Grass/Turf<br/> <input type="checkbox"/> Gravel<br/> <input type="checkbox"/> Ice         </div> <div style="width: 25%;"> <input type="checkbox"/> Macadam<br/> <input type="checkbox"/> Metal/Wood<br/> <input type="checkbox"/> Snow         </div> <div style="width: 25%;"> <input type="checkbox"/> Water<br/> <input type="checkbox"/> Unknown         </div> </div>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| <b>Approach/Departure Segment</b> <i>(Select one)</i><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="radio"/> Taxi<br/> <input type="radio"/> Takeoff<br/> <input type="radio"/> Initial Climb         </div> <div style="width: 25%;"> <input type="radio"/> VFR Departure<br/> <input type="radio"/> IFR Departure Procedure/Clearance         </div> <div style="width: 25%;"> <input type="radio"/> On Instrument Approach<br/> <input type="radio"/> Landing         </div> <div style="width: 25%;"> <input type="radio"/> Downwind<br/> <input type="radio"/> Base<br/> <input type="radio"/> Final<br/> <input type="radio"/> Crosswind         </div> <div style="width: 25%;"> <input type="radio"/> Low Approach<br/> <input type="radio"/> Go Around<br/> <input type="radio"/> Aborted Landing (after touchdown)<br/> <input type="radio"/> Unknown         </div> </div>                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| <b>IFR Approach</b> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> ADF/NDDB<br/> <input type="checkbox"/> SDF<br/> <input type="checkbox"/> VOR/TVOR<br/> <input type="checkbox"/> VOR/DME<br/> <input type="checkbox"/> TACAN         </div> <div style="width: 25%;"> <input type="checkbox"/> PAR<br/> <input type="checkbox"/> Sidestep<br/> <input type="checkbox"/> ILS<br/> <input type="checkbox"/> Localizer Only<br/> <input type="checkbox"/> LOC-back course<br/> <input type="checkbox"/> RNAV         </div> <div style="width: 25%;"> <input type="checkbox"/> MLS<br/> <input type="checkbox"/> LDA<br/> <input type="checkbox"/> ASR<br/> <input type="checkbox"/> Visual<br/> <input type="checkbox"/> Contact<br/> <input type="checkbox"/> Circling         </div> <div style="width: 25%;"> <input type="checkbox"/> Practice<br/> <input type="checkbox"/> GPS<br/> <input type="checkbox"/> Unknown         </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>VFR Approach</b> <i>(Check all that apply)</i><br><input type="checkbox"/> None<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Traffic Pattern<br/> <input type="checkbox"/> Straight-In<br/> <input type="checkbox"/> Valley/Terrain Following<br/> <input type="checkbox"/> Go Around<br/> <input type="checkbox"/> Full Stop         </div> <div style="width: 50%;"> <input type="checkbox"/> Stop and Go<br/> <input type="checkbox"/> Touch and Go<br/> <input type="checkbox"/> Simulated Forced Landing<br/> <input type="checkbox"/> Forced Landing<br/> <input type="checkbox"/> Precautionary Landing<br/> <input type="checkbox"/> Unknown         </div> </div>                                                                                                                                                                                                                |  |

| "FLIGHT CREWMEMBER 1" INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------|--------------|-------------------|------------------------|----------------------|-------|------------|--|------------|--------|------------------|--------|-----------|------------------------|-----|----|-----|---|----|---|----|---|---|---|------------------------|-----|----|-----|---|----|---|----|---|---|---|--------------------|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--------------|-----|----|-----|---|--|---|---|---|---|---|--------------|-----|----|-----|---|--|---|---|---|---|---|---------------|-----|-----|-----|---|--|---|---|---|---|---|
| "Flight Crewmember 1" Responsibilities at the Time of Accident/Incident<br><input checked="" type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| "Flight Crewmember 1" was pilot flying <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| "Flight Crewmember 1" Identification<br>First Name: <u>CHAEWON KO</u> City of Residence: <u>(TEMPORARY) SAN DIEGO</u><br>Middle Initial: _____    State: <u>CA</u> ZIP: <u>92111</u><br>Last Name: <u>KO</u> Country: <u>USA</u><br>Age at time of Accident/Incident: <u>31</u> Date of Birth: _____<br>Certificate Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input checked="" 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><b>Available</b><br><input type="radio"/> None<br><input type="radio"/> Lap only<br><input checked="" 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 checked="" type="radio"/> 3-point<br><input type="radio"/> 4-point<br><input type="radio"/> 5-point<br><input type="radio"/> Unknown |           |            | <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> (Check all that apply)<br><input type="checkbox"/> None <input type="checkbox"/> Flight Instructor <input type="checkbox"/> Commercial <input type="checkbox"/> US Military<br><input checked="" type="checkbox"/> Private <input type="checkbox"/> Recreational <input type="checkbox"/> Airline Transport <input checked="" type="checkbox"/> Foreign<br><input type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input checked="" type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                                                                                                                                                                            |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input type="radio"/> Other<br><input checked="" type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                   | <b>Medical Certificate Validity</b><br><input type="radio"/> Without limitations/waivers <input type="radio"/> Unknown<br><input checked="" type="radio"/> With limitations/waivers <input type="radio"/> N/A<br><input type="radio"/> Special Issuance                                                                             |                      |       | <b>Date of Last Medical</b><br><u>05/11/2017</u><br><small>mm/dd/yyyy</small>                                                                                                                                                                                                                                                                                                                                                                                                          |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Medical Certificate Limitations</b><br><u>MUST WEAR CORRECTIVE LENSES</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Medical Certificate Special Issuance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> <u>05/22/2017</u><br><small>mm/dd/yyyy</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       | <b>Flight Review Aircraft</b><br>Make: <u>PIPER</u><br>Model: <u>PA 28-161</u>                                                                                                                                                                                                                                                                                                                                                                                                         |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Airplane Rating(s)</b> (Check all that apply)<br><input type="checkbox"/> None<br><input checked="" type="checkbox"/> Single-Engine Land<br><input type="checkbox"/> Single-Engine Sea<br><input type="checkbox"/> Multiengine Land<br><input type="checkbox"/> Multiengine Sea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                   | <b>Other Aircraft Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airship<br><input type="checkbox"/> Balloon<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift |                      |       | <b>Instrument Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Powered Lift                                                                                                                                                                                                                                                                    |           |            | <b>Instructor Rating(s)</b> (Check all that apply)<br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Airplane Single-Engine<br><input type="checkbox"/> Airplane Multi-Engine<br><input type="checkbox"/> Gyroplane<br><input type="checkbox"/> Powered Lift<br><input type="checkbox"/> Instrument Airplane<br><input type="checkbox"/> Instrument Helicopter<br><input type="checkbox"/> Helicopter<br><input type="checkbox"/> Glider<br><input type="checkbox"/> Sport |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <b>Type Ratings</b> <u>N/A</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       | <b>Student Endorsements</b> (Include dates)<br><u>N/A</u>                                                                                                                                                                                                                                                                                                                                                                                                                              |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">Flight Time (Enter appropriate number of hours in each box)</th> <th rowspan="2">All Aircraft</th> <th rowspan="2">This Make &amp; Model</th> <th rowspan="2">Airplane Single Engine</th> <th rowspan="2">Airplane Multiengine</th> <th rowspan="2">Night</th> <th colspan="2">Instrument</th> <th rowspan="2">Rotorcraft</th> <th rowspan="2">Glider</th> <th rowspan="2">Lighter Than Air</th> </tr> <tr> <th>Actual</th> <th>Simulated</th> </tr> </thead> <tbody> <tr> <td>Total Time (ESTIMATED)</td> <td>280</td> <td>50</td> <td>280</td> <td>0</td> <td>25</td> <td>0</td> <td>80</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Pilot in Command (PIC)</td> <td>190</td> <td>46</td> <td>190</td> <td>0</td> <td>25</td> <td>0</td> <td>80</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Time as Instructor</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>This Make/Model</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Last 90 Days</td> <td>102</td> <td>50</td> <td>102</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Last 30 Days</td> <td>102</td> <td>50</td> <td>102</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Last 24 Hours</td> <td>5.7</td> <td>5.7</td> <td>5.7</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | Flight Time (Enter appropriate number of hours in each box) | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time (ESTIMATED) | 280 | 50 | 280 | 0 | 25 | 0 | 80 | 0 | 0 | 0 | Pilot in Command (PIC) | 190 | 46 | 190 | 0 | 25 | 0 | 80 | 0 | 0 | 0 | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days | 102 | 50 | 102 | 0 |  | 0 | 0 | 0 | 0 | 0 | Last 30 Days | 102 | 50 | 102 | 0 |  | 0 | 0 | 0 | 0 | 0 | Last 24 Hours | 5.7 | 5.7 | 5.7 | 0 |  | 0 | 0 | 0 | 0 | 0 |
| Flight Time (Enter appropriate number of hours in each box)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | All Aircraft | This Make & Model | Airplane Single Engine                                                                                                                                                                                                                                                                                                              | Airplane Multiengine | Night | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           | Rotorcraft | Glider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Lighter Than Air |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Simulated |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Total Time (ESTIMATED)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 280          | 50                | 280                                                                                                                                                                                                                                                                                                                                 | 0                    | 25    | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 80        | 0          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 190          | 46                | 190                                                                                                                                                                                                                                                                                                                                 | 0                    | 25    | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 80        | 0          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                   |                                                                                                                                                                                                                                                                                                                                     |                      |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 102          | 50                | 102                                                                                                                                                                                                                                                                                                                                 | 0                    |       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0         | 0          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 102          | 50                | 102                                                                                                                                                                                                                                                                                                                                 | 0                    |       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0         | 0          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5.7          | 5.7               | 5.7                                                                                                                                                                                                                                                                                                                                 | 0                    |       | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0         | 0          | 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0                |                                                             |              |                   |                        |                      |       |            |  |            |        |                  |        |           |                        |     |    |     |   |    |   |    |   |   |   |                        |     |    |     |   |    |   |    |   |   |   |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |     |    |     |   |  |   |   |   |   |   |              |     |    |     |   |  |   |   |   |   |   |               |     |     |     |   |  |   |   |   |   |   |

| <b>"FLIGHT CREWMEMBER 2" INFORMATION</b> <span style="float: right; font-family: cursive;">NONE</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
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| <b>"Flight Crewmember 2" Responsibilities at the Time of Accident/Incident</b><br><input type="radio"/> Pilot <input type="radio"/> Co-Pilot <input type="radio"/> Student Pilot <input type="radio"/> Flight Instructor <input type="radio"/> Check Pilot <input type="radio"/> Flight Engineer <input type="radio"/> Other Flight Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 2" was pilot flying</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>"Flight Crewmember 2" Identification</b><br><div style="display: flex; justify-content: space-between;"> <div>           First Name: _____<br/>           Middle Initial: _____<br/>           Last Name: _____         </div> <div>           City of Residence: _____<br/>           State: _____ ZIP: _____<br/>           Country: _____         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;">           Age at time of Accident/Incident: _____           Date of Birth: _____ <i>mm/dd/yyyy</i> </div> <div style="text-align: center; margin-top: 5px;">           Certificate Number: _____         </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Degree of Injury</b><br><input type="radio"/> None <input type="radio"/> Fatal<br><input type="radio"/> Minor <input type="radio"/> Unknown<br><input type="radio"/> Serious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              | <b>Seat Occupied</b><br><input 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 style="display: flex; justify-content: space-between;"> <div> <b>Available</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> <div> <b>Used</b><br/> <input type="radio"/> None<br/> <input type="radio"/> Lap only<br/> <input type="radio"/> 3-point<br/> <input type="radio"/> 4-point<br/> <input type="radio"/> 5-point<br/> <input type="radio"/> Unknown               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               | <b>Inflatable Restraints</b><br><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>Pilot Certificate(s) (Check all that apply)</b><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> None</div> <div style="width: 50%;"><input type="checkbox"/> Flight Instructor</div> <div style="width: 50%;"><input type="checkbox"/> Commercial</div> <div style="width: 50%;"><input type="checkbox"/> US Military</div> <div style="width: 50%;"><input type="checkbox"/> Private</div> <div style="width: 50%;"><input type="checkbox"/> Recreational</div> <div style="width: 50%;"><input type="checkbox"/> Airline Transport</div> <div style="width: 50%;"><input type="checkbox"/> Foreign</div> <div style="width: 50%;"><input type="checkbox"/> Student</div> <div style="width: 50%;"><input type="checkbox"/> Sport</div> <div style="width: 50%;"><input type="checkbox"/> Flight Engineer</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                          |                        | <b>Medical Certificate Validity</b><br><input 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><div style="text-align: center;">_____ <i>mm/dd/yyyy</i></div> |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Principal Occupation</b><br><input type="radio"/> Pilot<br><input type="radio"/> Other<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              | <b>Medical Certificate</b><br><input type="radio"/> None <input type="radio"/> Class 3<br><input type="radio"/> Class 1 <input type="radio"/> Driver's License (Sport Pilot only)<br><input type="radio"/> Class 2 <input type="radio"/> Unknown                                                                         |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Limitations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Medical Certificate Special Issuance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Date of Last Flight Review or Equivalent, Including FAR 121/135 Checks:</b> _____ <i>mm/dd/yyyy</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                          |                        | <b>Flight Review Aircraft</b><br>Make: _____<br>Model: _____                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Airplane Rating(s) (Check all that apply)</b><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) (Check all that apply)</b><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) (Check all that apply)</b><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) (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Airplane Single-Engine<br/> <input type="checkbox"/> Airplane Multi-Engine<br/> <input type="checkbox"/> Gyroplane<br/> <input type="checkbox"/> Powered Lift               </div> <div> <input type="checkbox"/> Instrument Airplane<br/> <input type="checkbox"/> Instrument Helicopter<br/> <input type="checkbox"/> Helicopter<br/> <input type="checkbox"/> Glider<br/> <input type="checkbox"/> Sport               </div> </div> |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <b>Type Ratings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Student Endorsements (Include dates)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2" style="text-align: left; padding: 5px;">Flight Time <i>(Enter appropriate number of hours in each box)</i></th> <th rowspan="2" style="padding: 5px;">All Aircraft</th> <th rowspan="2" style="padding: 5px;">This Make &amp; Model</th> <th rowspan="2" style="padding: 5px;">Airplane Single Engine</th> <th rowspan="2" style="padding: 5px;">Airplane Multiengine</th> <th rowspan="2" style="padding: 5px;">Night</th> <th colspan="2" style="padding: 5px;">Instrument</th> <th rowspan="2" style="padding: 5px;">Rotorcraft</th> <th rowspan="2" style="padding: 5px;">Glider</th> <th rowspan="2" style="padding: 5px;">Lighter Than Air</th> </tr> <tr> <th style="padding: 5px;">Actual</th> <th style="padding: 5px;">Simulated</th> </tr> </thead> <tbody> <tr> <td style="text-align: left; padding: 5px;">Total Time</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Pilot in Command (PIC)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Time as Instructor</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">This Make/Model</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 90 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 30 Days</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: left; padding: 5px;">Last 24 Hours</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table> |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  | Flight Time <i>(Enter appropriate number of hours in each box)</i> | All Aircraft | This Make & Model | Airplane Single Engine | Airplane Multiengine | Night | Instrument |  | Rotorcraft | Glider | Lighter Than Air | Actual | Simulated | Total Time |  |  |  |  |  |  |  |  |  |  | Pilot in Command (PIC) |  |  |  |  |  |  |  |  |  |  | Time as Instructor |  |  |  |  |  |  |  |  |  |  | This Make/Model |  |  |  |  |  |  |  |  |  |  | Last 90 Days |  |  |  |  |  |  |  |  |  |  | Last 30 Days |  |  |  |  |  |  |  |  |  |  | Last 24 Hours |  |  |  |  |  |  |  |  |  |  |
| Flight Time <i>(Enter appropriate number of hours in each box)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | All Aircraft | This Make & Model                                                                                                                                                                                                                                                                                                        | Airplane Single Engine | Airplane Multiengine                                                                                                                                                                                                                         | Night                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Instrument                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               | Rotorcraft                                                                                                                                                                                                                     | Glider | Lighter Than Air |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Actual                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Simulated                                                                                     |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Total Time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Pilot in Command (PIC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Time as Instructor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| This Make/Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 90 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 30 Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |
| Last 24 Hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                                                                                                                                                                                          |                        |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                                                                                                                                |        |                  |                                                                    |              |                   |                        |                      |       |            |  |            |        |                  |        |           |            |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |  |

| <b>ADDITIONAL FLIGHT CREWMEMBERS</b> (Exclusive of cabin crew, complete the following information)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                           |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>NONE</b>                                                                                                                                                                                                                    |                                                                                                                                                                                                                                |                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Crew Name and Address</b><br>First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                            |  |                                                                           |                                                                                                                                                         | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown <input type="radio"/> Unknown                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                    |                                                                                                                                                                                                                                |                                                                                                                                                                                          |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><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 type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer |  |                                                                           |                                                                                                                                                         | <b>Restraint Type:</b><br><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 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <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><br>First Name: _____ City of Residence: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____                                                                                                                                                                                                                                                                                                            |  |                                                                           |                                                                                                                                                         | <b>Seat Occupied</b><br><input type="radio"/> Left <input type="radio"/> Front<br><input type="radio"/> Center <input type="radio"/> Rear<br><input type="radio"/> Right <input type="radio"/> Single<br><input type="radio"/> Unknown <input type="radio"/> Unknown                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                    |                                                                                                                                                                                                                                |                                                                                                                                                                                          |  |
| <b>Pilot Certificate(s)</b> (Check all that apply)<br><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 type="checkbox"/> Student <input type="checkbox"/> Sport <input type="checkbox"/> Flight Engineer |  |                                                                           |                                                                                                                                                         | <b>Restraint Type:</b><br><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 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <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>PASSENGER(S) / OTHER PERSONNEL</b> (Include cabin crew; continue on separate sheet if necessary)                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                           |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                |                                                                                                                                                                                                                                | <b>NONE</b>                                                                                                                                                                              |  |
| <b>Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                    |  |                                                                           | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                       | <b>Restraint Type</b><br><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 |                                                                                                                                                                                                                                | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <b>Age</b><br><input type="checkbox"/> Under 5 years<br>If Under 5:<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |  |
| <b>Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                    |  |                                                                           | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                       | <b>Restraint Type</b><br><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 |                                                                                                                                                                                                                                | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <b>Age</b><br><input type="checkbox"/> Under 5 years<br>If Under 5:<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |  |
| <b>Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                    |  |                                                                           | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                       | <b>Restraint Type</b><br><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 |                                                                                                                                                                                                                                | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <b>Age</b><br><input type="checkbox"/> Under 5 years<br>If Under 5:<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |  |
| <b>Name and Address</b><br>First Name: _____ City: _____<br>Middle Initial: _____ State: _____ ZIP: _____<br>Last Name: _____ Country: _____<br><input type="radio"/> Crew <input type="radio"/> Passenger <input type="radio"/> Other                                                                                                                                                                                                                                    |  |                                                                           | <b>Seat</b><br><input type="radio"/> Left<br><input type="radio"/> Center<br><input type="radio"/> Right<br><input type="radio"/> Unknown<br>Row: _____ | <b>Injury</b><br><input type="radio"/> None<br><input type="radio"/> Minor<br><input type="radio"/> Serious<br><input type="radio"/> Fatal<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                       | <b>Restraint Type</b><br><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 |                                                                                                                                                                                                                                | <b>Inflatable Restraints</b><br><input type="checkbox"/> Not Installed<br><input type="checkbox"/> Installed<br><input type="checkbox"/> Not Deployed<br><input type="checkbox"/> Deployed<br><input type="checkbox"/> Unknown | <b>Age</b><br><input type="checkbox"/> Under 5 years<br>If Under 5:<br><input type="checkbox"/> Child Restraint<br><input type="checkbox"/> Lap-Held<br><input type="checkbox"/> Unknown |  |

| FLIGHT ITINERARY INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Last Departure Point</b><br>Airport ID: <u>KMYF</u><br>City: <u>San Diego</u><br>State: <u>CA</u><br>Country: <u>U.S.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Time of Departure</b><br>Time: <u>11:30</u><br>Time Zone: <u>Pacific</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Destination</b><br>Airport ID: <u>KTOZA</u><br>City: <u>SANTA YNEZ</u><br>State: <u>CA</u><br>Country: <u>US</u>                                                                                                                                | <b>Type Flight Plan Filed</b><br><input 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 checked="" type="radio"/> VFR<br>Activated? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                          |
| <b>Type of ATC Clearance/Service (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None <input type="checkbox"/> Special VFR<br/> <input type="checkbox"/> VFR <input type="checkbox"/> IFR             </div> <div> <input type="checkbox"/> Special IFR<br/> <input type="checkbox"/> VFR On Top             </div> <div> <input checked="" type="checkbox"/> VFR Flight Following<br/> <input type="checkbox"/> Traffic Advisory             </div> <div> <input type="checkbox"/> Cruise<br/> <input type="checkbox"/> Unknown / NA             </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Airspace where the accident/incident occurred (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Class A <input type="checkbox"/> Class G<br/> <input type="checkbox"/> Class B <input type="checkbox"/> Demo Area<br/> <input type="checkbox"/> Class C <input type="checkbox"/> Warning Area<br/> <input type="checkbox"/> Class D <input type="checkbox"/> Prohibited Area<br/> <input checked="" type="checkbox"/> Class E <input type="checkbox"/> Restricted Area             </div> <div> <input type="checkbox"/> Military Operations Area (MOA)<br/> <input type="checkbox"/> Airport Advisory Area<br/> <input type="checkbox"/> Jet Training Area<br/> <input type="checkbox"/> TRSA<br/> <input type="checkbox"/> FAR 93             </div> <div> <input type="checkbox"/> Special<br/> <input type="checkbox"/> Air Traffic Control Area<br/> <input type="checkbox"/> Unknown             </div> <div> <b>Altitude of In-Flight Occurrence:</b><br/> <div style="border-bottom: 1px solid black; width: 100px;"></div>             ft msl           </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| WEATHER INFORMATION AT THE ACCIDENT/INCIDENT SITE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Source of Pilot Weather Information (Check all that apply)</b><br><input type="checkbox"/> National Weather Service<br><input checked="" type="checkbox"/> Flight Service Station<br><input type="checkbox"/> TV/Radio<br><input checked="" type="checkbox"/> Automated Report<br><input type="checkbox"/> Commercial Weather Service (DUATS)<br><input type="checkbox"/> On-Board Weather                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Weather Observation Facility</b><br>Facility ID: <u>Santa Barbara ATIS</u><br>Observation Time: <u>14:00</u><br>Time Zone: <u>PACIFIC</u><br>Distance from Accident Site: <u>20</u> nm<br>Direction from Accident Site: <u>100</u> degrees true |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Basic Conditions</b><br><input checked="" type="radio"/> VMC<br><input type="radio"/> IMC<br><input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Light Condition</b><br><input type="radio"/> Dawn <input type="radio"/> Dusk <input type="radio"/> Dark Night <input type="radio"/> Unknown<br><input checked="" type="radio"/> Day <input type="radio"/> Night <input type="radio"/> Bright Night                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Sky/Lowest Cloud Condition</b><br><input type="radio"/> Clear <input type="radio"/> Thin Broken<br><input type="radio"/> Few <input type="radio"/> Thin Overcast<br><input type="radio"/> Partial Obscuration <input checked="" type="radio"/> Unknown<br><input type="radio"/> Scattered<br><b>Lowest Cloud Condition Height</b><br><u>2,400</u> ft agl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Ceiling</b><br><input type="radio"/> None (Clear) <input type="radio"/> Obscured<br><input type="radio"/> Broken <input type="radio"/> Indefinite<br><input checked="" type="radio"/> Overcast <input type="radio"/> Unknown<br><b>Ceiling Height</b><br><u>2,200</u> ft agl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Temperature:</b> <u>21</u> (C) or _____ (F)<br><b>Dew Point:</b> <u>13</u> (C) or _____ (F)<br><b>Altimeter Setting:</b> <u>29.85</u> in. Hg<br>or _____ MB                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Wind Direction</b><br><input type="checkbox"/> Variable <u>050</u><br>Direction: <u>170</u> degrees true                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Wind Speed</b><br><input type="checkbox"/> Calm<br><input type="checkbox"/> Light and Variable<br>Speed: <u>7</u> kts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Wind Gusts</b><br><input checked="" type="checkbox"/> Not Gusting<br>Speed: _____ kts                                                                                                                                                           | <b>Visibility</b> <u>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 (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> None<br/> <input type="checkbox"/> Rain<br/> <input type="checkbox"/> Snow<br/> <input type="checkbox"/> Hail<br/> <input type="checkbox"/> Rain Showers             </div> <div> <input type="checkbox"/> Drizzle<br/> <input type="checkbox"/> Ice Pellets<br/> <input type="checkbox"/> Snow Pellets<br/> <input type="checkbox"/> Snow Grains<br/> <input type="checkbox"/> Ice Crystals             </div> <div> <input type="checkbox"/> Freezing Rain<br/> <input type="checkbox"/> Snow Shower<br/> <input type="checkbox"/> Ice Pellets Shower<br/> <input type="checkbox"/> Freezing Drizzle             </div> </div> |                                                                                                                                                                                                                                                    | <b>Restriction to Visibility (Check all that apply)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Blowing Dust<br/> <input type="checkbox"/> Blowing Sand<br/> <input type="checkbox"/> Blowing Snow<br/> <input type="checkbox"/> Blowing Spray<br/> <input type="checkbox"/> Dust             </div> <div> <input type="checkbox"/> Fog<br/> <input type="checkbox"/> Ground Fog<br/> <input type="checkbox"/> Haze<br/> <input type="checkbox"/> Ice Fog<br/> <input type="checkbox"/> Smoke<br/> <input type="checkbox"/> Unknown             </div> </div> |
| <b>Icing Forecast</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Amount</b><br/> <input checked="" type="radio"/> None<br/> <input type="radio"/> Trace<br/> <input type="radio"/> Light<br/> <input type="radio"/> Moderate<br/> <input type="radio"/> Severe<br/> <input type="radio"/> Unknown             </div> <div style="flex: 1;"> <b>Type</b><br/> <input type="radio"/> N/A<br/> <input type="radio"/> Rime<br/> <input type="radio"/> Clear<br/> <input type="radio"/> Mixed<br/> <input type="radio"/> Unknown             </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Icing Actual</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Amount</b><br/> <input checked="" type="radio"/> None<br/> <input type="radio"/> Trace<br/> <input type="radio"/> Light<br/> <input type="radio"/> Moderate<br/> <input type="radio"/> Severe<br/> <input type="radio"/> Unknown             </div> <div style="flex: 1;"> <b>Type</b><br/> <input type="radio"/> N/A<br/> <input type="radio"/> Rime<br/> <input type="radio"/> Clear<br/> <input type="radio"/> Mixed<br/> <input type="radio"/> Unknown             </div> </div>                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                    | <b>Turbulence</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>Type (Check all that apply)</b><br/> <input type="checkbox"/> None<br/> <input type="checkbox"/> Clear Air<br/> <input type="checkbox"/> Terrain-Induced<br/> <input type="checkbox"/> Convective Turbulence             </div> <div style="flex: 1;"> <b>Severity</b><br/> <input type="checkbox"/> Light<br/> <input type="checkbox"/> Moderate<br/> <input type="checkbox"/> Severe<br/> <input type="checkbox"/> Extreme             </div> </div>                                                                                                                      |
| <b>NOTAMS (D and FDC), AIRMETs, SIGMETs, PIREPs in effect at the time of the accident/incident:</b><br><div style="height: 40px; border: 1px solid black;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| DAMAGE TO AIRCRAFT AND OTHER PROPERTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                        |
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| <b>Aircraft Damage</b><br><input type="radio"/> None <input checked="" type="radio"/> Substantial<br><input type="radio"/> Minor <input type="radio"/> Destroyed<br><input type="radio"/> <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Aircraft Fire</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Fire at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown | <b>Aircraft Explosion</b><br><input checked="" type="radio"/> None <input type="radio"/> Both Ground and In-Flight<br><input type="radio"/> In-Flight <input type="radio"/> Explosion at Unknown Time<br><input type="radio"/> On-Ground <input type="radio"/> Unknown |
| <b>Description of Damage to Aircraft and Other Property</b> <i>(Use additional sheet if necessary)</i><br><div style="border: 1px solid black; padding: 10px; min-height: 100px;"> <p>REPORTED: AIRCRAFT WINGS BOTH BROKEN, SUBSTANTIAL DAMAGE TO NOSE SECTION. OPERATOR HAS NOT YET SEEN AIRCRAFT</p> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                        |
| <b>NARRATIVE HISTORY OF FLIGHT</b> <i>(Please type or print in ink)</i><br><div style="border: 1px solid black; padding: 10px; min-height: 300px;"> <p>Describe what occurred in chronological order, including circumstances leading to and nature of accident/incident. Describe terrain and include wreckage distribution sketch if pertinent. Attach extra sheets if needed. State departure time and and location, services obtained, and intended destination. Provide as much detail as possible.</p> <p>From KMFE to KJZA, the last times were several in overcast clouds. Base of clouds in Santa Barbara was 2,200 ft. I started descending to get ground insight. I reached 2,100 ft, still in a thick cloud, couldn't see outside without having decision to climb or call for ATC. I crashed on a mountain.</p> </div> |                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                        |

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>RECOMMENDATION</b> (How could this accident/incident have been prevented?)                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| Operator/Owner Safety Recommendation                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| <b>MECHANICAL MALFUNCTION/FAILURE</b> (If more space is needed, continue on separate sheet)                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| Was there Mechanical Malfunction/Failure? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><i>(If yes, list the name of the part, manufacturer, part no., serial no., and describe the failure.)</i>                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            | <b>Total Time/Cycles On Part</b><br><br>_____ Hours<br>_____ Cycles<br><br><b>Time Since This Part Inspected/Overhauled</b><br><br>_____ Hours |
| <b>FUEL &amp; SERVICES INFORMATION</b>                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| <b>Fuel on Board at Last Takeoff</b><br><i>(Convert from pounds, as necessary)</i><br><br><div style="display: flex; align-items: center;"> <span style="font-size: 1.5em; margin-right: 10px;">46</span> <span>Gallons</span> </div>                                     | <b>Fuel Type</b><br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="radio"/> 80/87      <input type="radio"/> 115/145      <input type="radio"/> Jet B      <input type="radio"/> Other, specify _____<br/> <input checked="" type="radio"/> 100 Low Lead      <input type="radio"/> Jet A      <input type="radio"/> JP8<br/> <input type="radio"/> 100/130      <input type="radio"/> Jet A-1      <input type="radio"/> Automotive         </div> </div> |                                                                                                                                                                            |                                                                                                                                                |
| Other Services, if Any, Prior to Departure                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| <b>EVACUATION OF AIRCRAFT</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| Was an emergency evacuation of the aircraft performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| Method of Exit - Describe how the occupants exited and how many occupants evacuated each location<br><div style="font-family: cursive; font-size: 1.2em; padding: 10px;">           MR KO WAS RESCUED BY A RESCUE TEAM, BY HELICOPTER. NO OTHER OCCUPANTS.         </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| <b>OTHER AIRCRAFT - COLLISION</b> (If air or ground collision occurred, complete this section for other aircraft) <span style="float: right;">NONE</span>                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                            |                                                                                                                                                |
| Aircraft Registration Number                                                                                                                                                                                                                                              | Manufacturer: _____<br>Model: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Damage to Other Aircraft</b><br><input type="checkbox"/> Destroyed <input type="checkbox"/> Minor<br><input type="checkbox"/> Substantial <input type="checkbox"/> None |                                                                                                                                                |
| <b>Registered Owner of Other Aircraft</b><br>Name: _____<br>City: _____<br>State: _____ ZIP: _____<br>Country: _____                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Pilot of Other Aircraft</b><br>Name: _____<br>City: _____<br>State: _____ ZIP: _____<br>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

6/14/2017

mm/dd/yyyy

Name of Pilot/Operator:

Chester Co

Signature:

-- or --

☐ Check here to electronically sign this document

If a Person Other than Pilot/Operator is Filing Report

Name:

EMIL SCOTT PATTERMAN

Signature:

-- or --

☐ Check here to electronically sign this document

Title:

FLIGHT INSTRUCTOR  
NATIONAL AIR COLLEGE**FOR NTSB USE ONLY**

NTSB Accident/Incident No.

WPR17CA124

Reviewed by NTSB Regional Office

WPR/Federal Way, WA

Name of Investigator

Tom Little

Date Report Received

6/30/2017