DECEASED (If More Than 2 Fatalities, Attach Additional Forms)

NAME OF VICTIM | ADDRESS OF VICTIM | WAS PFD WORN? ☐ Yes ☐ No

DATE OF BIRTH | ☐ Male ☐ Female | DEATH CAUSED BY? ☐ Drowning ☐ Other ☐ Disappearance

NAME OF VICTIM | ADDRESS OF VICTIM | WAS PFD WORN? ☐ Yes ☐ No

DATE OF BIRTH | ☐ Male ☐ Female | DEATH CAUSED BY? ☐ Drowning ☐ Other ☐ Disappearance

INJURED (If More Than 2 Injuries, Attach Additional Forms)

NAME OF VICTIM | ADDRESS OF VICTIM

DATE OF BIRTH | MEDICAL TREATMENT BEYOND FIRST AID? ☐ Yes ☐ No | DESCRIBE INJURY
ADMITTED TO HOSPITAL? ☐ Yes ☐ No

WAS PFD WORN? ☐ Yes ☐ No PRIOR TO ACCIDENT? ☐ Yes ☐ No AS A RESULT OF ACCIDENT? ☐ Yes ☐ No
WAS IT INFLATABLE? ☐ Yes ☐ No

NAME OF VICTIM | ADDRESS OF VICTIM

DATE OF BIRTH | MEDICAL TREATMENT BEYOND FIRST AID? ☐ Yes ☐ No | DESCRIBE INJURY
ADMITTED TO HOSPITAL? ☐ Yes ☐ No

WAS PFD WORN? ☐ Yes ☐ No PRIOR TO ACCIDENT? ☐ Yes ☐ No AS A RESULT OF ACCIDENT? ☐ Yes ☐ No
WAS IT INFLATABLE? ☐ Yes ☐ No

OTHER PEOPLE ABOARD THIS BOAT (If More Than 2 People, Attached Additional Forms)

NAME | ADDRESS

DATE OF BIRTH | WAS PFD WORN? ☐ Yes ☐ No PRIOR TO ACCIDENT? ☐ Yes ☐ No
AS A RESULT OF ACCIDENT? ☐ Yes ☐ No WAS IT INFLATABLE? ☐ Yes ☐ No

NAME | ADDRESS

DATE OF BIRTH | WAS PFD WORN? ☐ Yes ☐ No PRIOR TO ACCIDENT? ☐ Yes ☐ No
AS A RESULT OF ACCIDENT? ☐ Yes ☐ No WAS IT INFLATABLE? ☐ Yes ☐ No

BOAT NO. 2 (If More Than 2 People, Attach Additional Forms)

NAME OF OPERATOR | OPERATOR ADDRESS

OPERATOR TELEPHONE NUMBER ( ) | BOAT REGISTRATION OR DOCUMENTATION NUMBER | STATE

NAME OF OWNER | OWNER ADDRESS

OWNER TELEPHONE NUMBER ( )

PROPERTY DAMAGE

ESTIMATED AMOUNT: | THIS BOAT AND CONTENTS $ | OTHER BOAT(S) AND CONTENTS: $ | OTHER PROPERTY: $

ACCIDENT DESCRIPTION: (Sequence of events. Include Failure of Equipment. If diagram is needed attach separately. Continue on additional sheets if necessary. Include any information regarding the involvement of alcohol and / or drugs in causing or cont

WITNESSES NOT ON THIS VESSEL

NAME | ADDRESS | TELEPHONE NUMBER ( )

NAME | ADDRESS | TELEPHONE NUMBER ( )

PERSON COMPLETING REPORT

NAME | ADDRESS | TELEPHONE NUMBER ( )

SIGNATURE | QUALIFICATION ☐ OPERATOR ☐ OWNER ☐ INVESTIGATOR ☐ OTHER | DATE SUBMITTED

FOR AGENCY USE ONLY

CAUSES BASED ON (**Check One**): ☐ This Report ☐ Investigation ☐ Investigation and This Report ☐ Other

NAME OF REVIEWING OFFICE | DATE RECEIVED | ☐ RECREATIONAL ☐ COMMERCIAL ☐ NON-REPORTABLE

PRIMARY CAUSE | SECONDARY CAUSE