

If more than 3 fatalities and/or injuries, attach additional form(s).

DECEASED

NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? <input type="checkbox"/> Swimmer <input type="checkbox"/> Non Swimmer	DEATH CAUSED BY <input type="checkbox"/> Drowning <input type="checkbox"/> Other <input type="checkbox"/> DISAPPEARANCE	WAS PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No What Type?
NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? <input type="checkbox"/> Swimmer <input type="checkbox"/> Non Swimmer	DEATH CAUSED BY <input type="checkbox"/> Drowning <input type="checkbox"/> Other <input type="checkbox"/> DISAPPEARANCE	WAS PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No What Type?
NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? <input type="checkbox"/> Swimmer <input type="checkbox"/> Non Swimmer	DEATH CAUSED BY <input type="checkbox"/> Drowning <input type="checkbox"/> Other <input type="checkbox"/> DISAPPEARANCE	WAS PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No What Type?

INJURED

NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED (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 contributing to the accident. Include any descriptive information about the use of PFD's.)

VESSEL NO. 2 (if more than 2 vessels, attach additional form(s)).

Name of Operator	Address	Boat Number
Telephone Number		Boat Name
Name of Owner	Address	

WITNESSES

Name	Address	Telephone Number
Name	Address	Telephone Number
Name	Address	Telephone Number

PERSON COMPLETING REPORT

SIGNATURE	Address	Telephone Number
QUALIFICATION (Check One) <input type="checkbox"/> Operator <input type="checkbox"/> Owner <input type="checkbox"/> Investigator <input type="checkbox"/> Other		Date Submitted

(do not use) - **FOR REPORTING AUTHORITY REVIEW** (use agency date stamp)

Causes based on (check one) <input type="checkbox"/> This report <input type="checkbox"/> Investigation and this report <input type="checkbox"/> Investigation <input type="checkbox"/> Could not be determined	Name of Reviewing Office	Date Received
Primary Cause of Accident	Secondary Cause of Accident	Reviewed By