

**SECTION A - ACCIDENT INFORMATION**

1. CHECK ONE <input type="checkbox"/> a. ORIGINAL <input type="checkbox"/> b. CHANGE		2. UIC (Unit Identification Code) (6-Digit Code of Unit Having Accident)		3a. UNIT NAME AND MILITARY ADDRESS (Accountable Unit)		3b. BRANCH (Armor, Infantry, etc.)	
4. DATE OF ACCIDENT		5. TIME OF ACCIDENT (Local Military Time)		6. PERIOD OF DAY (Check one)		7. ACCIDENT OCCURRED (Check one)	
a. YEAR	b. MONTH	c. DAY		<input type="checkbox"/> a. Dawn <input type="checkbox"/> b. Day <input type="checkbox"/> c. Dusk <input type="checkbox"/> d. Night	<input type="checkbox"/> a. On Post <input type="checkbox"/> b. Off Post	8. IF ON POST, NAME OF INSTALLATION/FACILITY	
10. WERE EXPLOSIVES OR AMMUNITION INVOLVED (Causal or Contributing Role)			11a. EXACT LOCATION OF ACCIDENT (Detailed enough to locate site)				
<input type="checkbox"/> Yes (See DA PAM 385-40) <input type="checkbox"/> No			11b. TYPE OF LOCATION		11c. GRID COORDINATES OR LAT/LONG		

**SECTION B - PERSONNEL INFORMATION**

12. NAME (Last, First, MI)		14. DOB (YYYYMMDD)		27. CLASSIFICATION AT TIME OF ACCIDENT (Check)		28. CAUSE OF INJURY/OCCUPATIONAL ILLNESS (Number in order of severity) (No more than 3)	
13. SOCIAL SECURITY NUMBER (SSN)		17. MOS OR JOB SERIES		<input type="checkbox"/> a. Active Army	<input type="checkbox"/> b. Army Civilian	a. Struck Against	g. Bodily Reaction
15. GENDER (Check) <input type="checkbox"/> a. Male <input type="checkbox"/> b. Female	16. RANK OR GRADE	17. MOS OR JOB SERIES		<input type="checkbox"/> c. Army Contractor	<input type="checkbox"/> d. Army Direct Contractor	b. Struck By	h. Overexertion
18a. ADDRESS (Use Official Address for All Military or Government Personnel) (If different than Block 3, add UIC.)		18b. For injured Army Civilians or Contractors, enter home address		<input type="checkbox"/> e. Nonappropriated Fund (NAF)	<input type="checkbox"/> f. Other U.S. Military	c. Fell from Elevation	i. Exposure
19a. DUTY STATUS AT TIME OF ACCIDENT (Check one)		19b. IF OFF DUTY (if on leave/pass)		<input type="checkbox"/> g. ROTC	29. BODY PART(S) AFFECTED (Number in order of severity) (No more than 3)		
<input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty	<input type="checkbox"/> Leave <input type="checkbox"/> Pass	Date From: _____ Date To: _____		<input type="checkbox"/> h. Dependent	<input type="checkbox"/> i. NGB Tech	a. Body (General)	m. Arm
20. FLIGHT STATUS (Check one) <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No				<input type="checkbox"/> j. NGB IDT	<input type="checkbox"/> k. NGB AT	b. Head	n. Wrist
21a. TIME BEGAN WORK: _____		21b. CONTINUOUS WORK w/o SLEEP: _____		<input type="checkbox"/> l. NGB ADSW	<input type="checkbox"/> m. NGB AGR	c. Forehead	o. Hand
22. HRS. SLEEP IN LAST 24: _____		23. DAYS LOST/RESTRICTED (not counting day of injury)		<input type="checkbox"/> n. NGB ADT	<input type="checkbox"/> o. NG Activated	d. Eyes	p. Fingers
a. Hospitalized: _____ Days		b. Not Hospitalized: _____ Days		<input type="checkbox"/> p. USAR IDT	<input type="checkbox"/> q. USAR AT	e. Nose	q. Leg
c. Restricted Activity: _____ Days		24. TREATED IN EMERGENCY ROOM <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No		<input type="checkbox"/> r. USAR ADT	<input type="checkbox"/> s. USAR FTM	f. Jaw	r. Knee
25a. OSHA 300 Log Case Number: _____		25b. Name of Physician/Health Care Provider: _____		<input type="checkbox"/> t. USAR AGR	30. TYPE OF INJURY/ILLNESS (Number to Correspond with Block 29)		
25c. If treatment was given away from worksite, where was it given? Facility: _____ Street: _____ City: _____ State: _____				<input type="checkbox"/> u. USAR Activated	<input type="checkbox"/> v. Foreign Nat. Direct Hire	g. Neck	s. Ankle
26. SEVERITY OF ILLNESS/INJURY (Check most severe)				<input type="checkbox"/> w. Foreign Nat. Indirect Hire	<input type="checkbox"/> x. Foreign Nat. KATUSA	h. Trunk	t. Foot
<input type="checkbox"/> a. Fatal (Date of Death _____)	<input type="checkbox"/> b. Permanent Total Disability. Person can never again do gainful work.		<input type="checkbox"/> y. Foreign Mil. Attached to the U.S. Army		<input type="checkbox"/> z. Public	i. Chest	u. Toes
<input type="checkbox"/> c. Permanent Partial Disability. Person loses or can never again use a body part	<input type="checkbox"/> d. Days Away from Work. Person misses one or more workdays; bed rest/on quarters.		<input type="checkbox"/> aa. Not reported			j. Heart	v. Other (Specify)
<input type="checkbox"/> e. Restricted Work Activity. Person is temporarily unable to perform regular duties; job transfer/light duty/profile.	<input type="checkbox"/> f. Medical Treatment Beyond First Aid. Loss of consciousness, needle stick, etc.					k. Back	
<input type="checkbox"/> g. First Aid Only. Person has one-time treatment of minor injury. (No lost work days.)	<input type="checkbox"/> h. No Injury.					l. Shoulder	
						a. Burns (Chemical)	m. Puncture Wound
						b. Burns (Thermal)	n. Hernia, Rupture
						c. Amputation	o. Frostbite
						d. Decompression Sickness	p. Heat Stroke
						e. Asphyxiation (Suffocation)	q. Heat Exhaustion
						f. Fractures	r. Noise Injury/Illness
						g. Dislocation	s. Needle Stick or Sharp
						h. Abrasions	t. Loss of Consciousness
						i. Concussion	u. Other (Specify)
						j. Sprain/Strain	
						k. Cuts/Lacerations	
						l. Contusion	



**SECTION B - PERSONNEL INFORMATION (Continued)**

41. If drug use by this individual caused/contributed to this accident, check appropriate block.

- a. Prescription     
  b. Illegal     
  c. Over-the-counter     
  d. Supplements     
  e. None

42. Were vision enhancement devices being used? (Check appropriate block.)

- a. Yes (Specify type/model in c and d.)     
  b. No     
 c. TYPE: \_\_\_\_\_     
 d. MODEL: \_\_\_\_\_

43. Standard/Reference covering activity/task

- |   |  |
|---|--|
| <input type="checkbox"/> a. Soldier's Manual (Task No.) _____ | <input type="checkbox"/> e. Federal/State Law      |
| <input type="checkbox"/> b. CTT (Task No.) _____              | <input type="checkbox"/> f. Other (Specify): _____ |
| <input type="checkbox"/> c. AR/TM/FM (Specify) _____          | <input type="checkbox"/> g. None (Go to Block 45.) |
| <input type="checkbox"/> d. SOP                               |  |

- |   |   |
|---|---|
| 44. WAS ACTIVITY/TASK PERFORMED IAW STANDARD/REFERENCE? (Check one)<br><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No (If NO, complete blocks 45-47.) | 45. DID INDIVIDUAL MAKE A MISTAKE? (Check one)<br><input type="checkbox"/> a. Yes (If YES, complete blocks 46-47.) <input type="checkbox"/> b. No |
|---|---|

46. What was the mistake? How was the activity/task performed incorrectly? (Explain below.)

47. Why was mistake made/activity performed incorrectly? (Check all that apply.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. Inadequate school training (content/amount)      | <input type="checkbox"/> g. Poor/bad attitude/indiscipline   | <input type="checkbox"/> m. Inadequate written procedures (AR, TM, SOP) |
| <input type="checkbox"/> b. Inadequate unit training (content/amount)        | <input type="checkbox"/> h. Lack of rest/sleep               | <input type="checkbox"/> n. Improper supervision                        |
| <input type="checkbox"/> c. Inadequate on-the-job training                   | <input type="checkbox"/> i. Effects of alcohol/drugs/illness | <input type="checkbox"/> o. Other (Specify in narrative)                |
| <input type="checkbox"/> d. Fear/excitement/anger                            | <input type="checkbox"/> j. Inadequate facilities            |   |
| <input type="checkbox"/> e. Overconfident in own/others abilities/complacent | <input type="checkbox"/> k. Inadequate services              |   |
| <input type="checkbox"/> f. In a hurry                                       | <input type="checkbox"/> l. Improper equipment design        |   |
|  |  |   |

- |   |  |   |
|---|--|---|
| 48. Time licensed on this vehicle (Check one)<br><input type="checkbox"/> a. Less than one year<br><input type="checkbox"/> b. One to two years<br><input type="checkbox"/> c. Over two years<br><input type="checkbox"/> d. Unlicensed   | 49. Total AMV driving mileage (Check one)<br><input type="checkbox"/> a. Less than 1,000 miles<br><input type="checkbox"/> b. 1,000 - 5,000 miles<br><input type="checkbox"/> c. 5,000 - 10,000 miles<br><input type="checkbox"/> d. Over 10,000 miles | 50a. Total time in unit (Check one)<br><input type="checkbox"/> Less than 6 months<br><input type="checkbox"/> 6 months - 1 year<br><input type="checkbox"/> Over one year<br><br>50b. Date Assigned/Hired (YYYYMMDD)<br>50c. Date of redeployment from combat zone, if applicable (YYYYMMDD) |
| 51. WHICH ITEM FROM SECTION C APPLIES TO THE INDIVIDUAL NAMED IN BLOCK 12? (This is needed in order to relate the person in Block 12 to the equipment/vehicle below.)<br><input type="checkbox"/> Item A <input type="checkbox"/> Item B <input type="checkbox"/> Item C <input type="checkbox"/> Other (Specify) _____ |  |   |

**SECTION C - PROPERTY/MATERIEL INVOLVED (Whether Damaged or Not)**

	ITEM A	ITEM B	ITEM C
52. Type of item			
53a. Model number			
53b. Serial number			
54. Ownership (DoD, DA, POV, Unit Person)			
55. Dollar cost of damage.			
56. Rollover protection system installed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
57. Was this item being towed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
58. If towed, enter letter for item doing towing.			
59. Types of collision codes (Pick up to three from list below and enter in blocks.) (In sequence)			

- Types of Collisions**
- |   |   |
|---|---|
| 1- Going forward and collided with moving vehicle<br>2- Going forward and collided with parked vehicle<br>3- Collision while backing<br>4- Collision with pedestrian<br>5- Collision with object (other than vehicle/pedestrian)<br>6- Overturned | 7- Ran off the road<br>8- Jackknifed<br>9- Going forward and rear-ended moving vehicle<br>10- Going forward and rear-ended parked vehicle<br>11- Collision while turning<br>12- Other (Specify) |
|---|---|

**SECTION C - PROPERTY/MATERIEL INVOLVED (Whether Damaged or Not) (Continued)**

60. Component/Part that Failed/Malfunctioned (Complete this section if a materiel failure/malfunction caused/contributed to the accident.)

	ITEM A	ITEM B	ITEM C
a. National Stock Number			
b. Part Number			
c. Describe Part			
d. Manufacturer's Identification Code			
e. EIR/QDR Number			

61. How/Why Part Malfunctioned (Select code from "How" list below and enter in first block; select code from "Why" list and enter in second block.)	HOW	WHY	HOW	WHY	HOW	WHY

**How Part Failed/Malfunctioned Codes:**

- 1 - Overheated/burned/melted
- 2 - Froze (*temperature*)
- 3 - Obstructed/pinched/clogged
- 4 - Vibrated
- 5 - Rubbed/worn/frayed
- 6 - Corroded/rusted/pitted
- 7 - Overpressured/burst
- 8 - Pulled/stretched
- 9 - Twisted/torqued
- 10 - Compressed/hit/punctured
- 11 - Bent/warped
- 12 - Sheared/cut
- 13 - Decayed/decomposed
- 14 - Electric current action
- 15 - Unknown/Other
- Blank - Not Reported

**Why Part Failed/Malfunctioned Codes:**

- 1 - Improper equipment design
- 2 - Inadequate maintenance
- 3 - Inadequate manufacture of equipment
- 4 - Inadequate written procedures (*AR, TM, SOP*)
- 5 - Improper supervision
- 6 - Unknown
- 7 - Other (*Specify in narrative*)

**SECTION D - ENVIRONMENTAL CONDITIONS INVOLVED**

62. Environmental Conditions. (Check environmental conditions present and indicate if conditions caused/contributed to the accident.)

PRESENT	CAUSED/ CONTRIBUTED	CONDITION	PRESENT	CAUSED/ CONTRIBUTED	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	a. Clear/dry; visibility unlimited	<input type="checkbox"/>	<input type="checkbox"/>	k. Wind gust/turbulence
<input type="checkbox"/>	<input type="checkbox"/>	b. Bright, glare	<input type="checkbox"/>	<input type="checkbox"/>	l. Vibrate, shimmy, sway, shake
<input type="checkbox"/>	<input type="checkbox"/>	c. Dark, dim	<input type="checkbox"/>	<input type="checkbox"/>	m. Radiation, laser, sunlight
<input type="checkbox"/>	<input type="checkbox"/>	d. Fog, condensation, frost	<input type="checkbox"/>	<input type="checkbox"/>	n. Holes, rocky, rough, rutted, uneven
<input type="checkbox"/>	<input type="checkbox"/>	e. Mist, rain, sleet, hail	<input type="checkbox"/>	<input type="checkbox"/>	o. Inclined/steep
<input type="checkbox"/>	<input type="checkbox"/>	f. Snow, ice	<input type="checkbox"/>	<input type="checkbox"/>	p. Slippery ( <i>not due to precipitation</i> )
<input type="checkbox"/>	<input type="checkbox"/>	g. Dust, fumes, gasses, smoke, vapors	<input type="checkbox"/>	<input type="checkbox"/>	q. Air pressure ( <i>bends, decompression, altitude, hypoxia</i> )
<input type="checkbox"/>	<input type="checkbox"/>	h. Noise, bang, static	<input type="checkbox"/>	<input type="checkbox"/>	r. Lightning, static electricity, ground
<input type="checkbox"/>	<input type="checkbox"/>	i. Temperature/humidity ( <i>cold, heat</i> )	<input type="checkbox"/>	<input type="checkbox"/>	s. Other ( <i>Specify</i> )
<input type="checkbox"/>	<input type="checkbox"/>	j. Storm, hurricane, tornado			

**SECTION E - ACCIDENT DESCRIPTION/NARRATIVE (From Blocks 10, 46, 47, 61 and 62)**

63. The investigation board will report, in narrative form on letter size paper, the facts, conditions, and circumstances as established during the investigation and present this information in accordance with DA PAM 385-40, paragraph 4-4.

64a. PRINTED/TYPED NAME OF PERSON COMPLETING THIS REPORT		64b. RANK	64c. TITLE
64d. SIGNATURE		64e. DATE OF SIGNATURE (YYYYMMDD)	64f. TELEPHONE NO.
			64g. EMAIL ADDRESS

**SECTION F - CORRECTIVE ACTION AND COMMAND REVIEW**

65. The investigation board will formulate the findings and recommendations on letter sized paper in accordance with the examples contained in DA PAM 385-40, paragraph 4-3.

66a. PRINTED/TYPED NAME OF COMMANDER

66b. RANK

66c. SIGNATURE

66d. DATE OF SIGNATURE  
(YYYYMMDD)

66e. TELEPHONE NO.

66f. EMAIL ADDRESS

	a. TYPED NAME/EMAIL ADDRESS	b. SIGNATURE	c. TITLE	d. RANK/DATE
67.				
68.				
69.				

**SECTION G - SAFETY OFFICE USE ONLY**

70. LOCAL REPORT NO.

71. ARMY HEADQUARTERS

72. ACCIDENT TYPE (Check choice)

<input type="checkbox"/> a. Army Motor Vehicle	<input type="checkbox"/> h. Other Army Vehicle	<input type="checkbox"/> o. Personal Injury - Other
<input type="checkbox"/> b. Army Combat Vehicle	<input type="checkbox"/> i. Fire	<input type="checkbox"/> p. Property Damage - Other
<input type="checkbox"/> c. Army Operated Vehicle	<input type="checkbox"/> j. Chemical Agent	<input type="checkbox"/> q. POV - On Official Business
<input type="checkbox"/> d. POV - Not on Official Business	<input type="checkbox"/> k. Explosive	<input type="checkbox"/> r. Space
<input type="checkbox"/> e. Marine Diving	<input type="checkbox"/> l. Missile	<input type="checkbox"/> s. Commercial Carrier/Transportation
<input type="checkbox"/> f. Marine Underway	<input type="checkbox"/> m. Radiation	
<input type="checkbox"/> g. Marine Not Underway	<input type="checkbox"/> n. Nuclear	

73. NAME OF SAFETY POINT OF CONTACT (POC)

74a. PHONE NO. OF SAFETY OFFICER POC  
(DSN, Commercial, etc.)

75. DATE REPORT COMPLETED BY SAFETY OFFICER  
(YYYYMMDD)

74b. EMAIL ADDRESS

**SECTION H - EXPLOSIVES/AMMUNITION**

76. EXPLOSIVE/AMMUNITION INFORMATION:	ITEM 1	ITEM 2	ITEM 3	ITEM 4
a. LOT #				
b. QUANTITY				
c. NET EXPLOSIVE WEIGHT (NEW)				
d. DoDIC/DoDAC				

77. SPECIAL INTEREST

78. SUPPLEMENTAL INFORMATION