



VIRGINIA BOATING ACCIDENT REPORT

Virginia Department of Game and Inland Fisheries
7870 Villa Park Dr., Suite 400, P.O. Box 90778, Henrico, VA 23228

Year:

Control No:

The operator/owner of a vessel used for recreational purposes is required to file a report in writing whenever an accident results in: loss of life or disappearance from a vessel; an injury which requires medical treatment beyond first aid; or property damage in excess of \$2000 or complete loss of the vessel. Reports in death and injury cases must be submitted within 48 hours. Reports in other cases must be submitted within 10 days. Reports must be submitted in person or by mail to the above address. This form is provided to assist the operator in filing the required written report.

COMPLETE ALL BLOCKS (indicate those not applicable by "NA")

NAME AND ADDRESS OF OPERATOR	AGE OF OPERATOR	OPERATOR'S EXPERIENCE	
	DATE OF BIRTH	This Type of Boat ___ Under 20 Hours ___ 20-100 Hours ___ 100-500 Hours ___ Over 500 Hours	Other Boat Operating Exp. ___ Under 20 Hours ___ 20-100 Hours ___ 100-500 Hours ___ Over 500 Hours
OPERATOR TELEPHONE NUMBER	OWNER TELEPHONE NUMBER		
NAME AND ADDRESS OF OPERATOR	RENTED BOAT? ___ Yes ___ No	NUMBER OF PERSONS ON BOARD	FORMAL INSTRUCTION IN BOATING SAFETY ___ None ___ State ___ U.S. Power Squadron ___ USCG Auxiliary ___ American Red Cross ___ Other (Specify)

VESSEL NO. 1 (this vessel)

BOAT REGISTRATION NO.	BOAT NAME	BOAT MAKE	BOAT MODEL	MFR. HULL ID NO.
TYPE OF BOAT ___ Open Motorboat ___ Cabin Motorboat ___ Auxiliary Sail ___ Sail (only) ___ Rowboat ___ Canoe ___ Other (Specify)	HULL MATERIAL ___ Wood ___ Aluminum ___ Steel ___ Fiberglass ___ Rubber/Vinyl ___ Other (Specify)	ENGINE ___ Outboard ___ Inboard Gasoline ___ Inboard Diesel ___ Inboard-Outdrive ___ Jet ___ Other (Specify)	PROPULSION No. of Engines: Horsepower (total): Type of Fuel:	CONSTRUCTION Length: Year built (boat):
Has boat had a Safety Examination? ___ Yes ___ No For current year? ___ Yes ___ No Year: _____ Indicate whether: ___ USCG Aux. Courtesy Marine Exam. ___ State/Local examination ___ Other				

ACCIDENT DATA

DATE OF ACCIDENT	TIME a.m. p.m.	NAME OF BODY OF WATER	LOCATION (Give location precisely) Lat: _____ Long: _____	
STATE	NEAREST CITY OR TOWN	COUNTY		
WEATHER ___ Clear ___ Rain ___ Cloudy ___ Snow ___ Fog ___ Hazy	WATER CONDITIONS ___ Calm (waves less than 6") ___ Choppy (waves 6"-2') ___ Rough (waves 2'-6') ___ Very Rough (greater than 6') ___ Strong Current	TEMPERATURE (Estimate) Air: _____ °F Water: _____ °F	WIND ___ None ___ Light (0-6 mph) ___ Moderate (7-14 mph) ___ Strong (15-25 mph) ___ Storm (Over 25 mph)	VISIBILITY Day ___ Night ___ ___ Good ___ ___ Fair ___ ___ Poor ___

OPERATION AT TIME OF ACCIDENT (Check all that apply) ___ Commercial Activity ___ Cruising ___ Maneuvering ___ Approaching Dock ___ Leaving Dock ___ Water Skiing ___ Towing ___ Skin Diving/Swimming ___ Other (Specify)	TYPE OF ACCIDENT ___ Grounding ___ Flooding ___ Falls in Boat ___ Fire or Explosion (fuel) ___ Fire or Explosion (other than fuel) ___ Collision with Vessel ___ Collision with Fixed Object ___ Collision with Floating Object ___ Falls Overboard ___ Hit by Boat or Propeller ___ Other (Specify)	WHAT IN YOUR OPINION CONTRIBUTED TO THE ACCIDENT? (Check all that apply) ___ Weather ___ Excessive Speed ___ No Proper Lookout ___ Restricted Vision ___ Overloading ___ Improper Loading ___ Hazardous Waters ___ Other (Specify) ___ Alcohol Use ___ Drug Use ___ Fault of Hull ___ Fault of Machinery ___ Fault of Equipment ___ Operator Inexperience ___ Operator Inattention
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PERSONAL FLOTATION DEVICES (PDF's)

Was the boat adequately equipped with Coast Guard approved Flotation Devices? ___ Yes ___ No
Were they accessible? ___ Yes ___ No
Were they serviceable? ___ Yes ___ No
Were they used by survivors? ___ Yes ___ No
What Type? ___ I ___ II ___ III ___ IV
___ V (Specify)
Were PFDs properly Used? ___ Yes ___ No
Adjusted? ___ Yes ___ No
Sized? ___ Yes ___ No

Was the vessel carrying Non-approved flotation devices? ___ Yes ___ No
Were they accessible? ___ Yes ___ No
Were they used? ___ Yes ___ No
If Yes, indicate kind

PROPERTY DAMAGE

Estimate amount
This Boat \$ _____
Other Boat \$ _____
Other Property \$ _____

FIRE EXTINGUISHERS

Were they used? (If yes, list type(s) and number used.)
___ Yes ___ No
Types: _____

DESCRIBE PROPERTY DAMAGE

NAME/ADDRESS-OWNER OF DAMAGED PROPERTY

Include any comments on PFDs under Accident Description on other side of form.

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

DECEASED

NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? ___ Swimmer ___ Non-swimmer	DEATH CAUSED BY ___ Drowning ___ Other ___ DISAPPEARANCE	WAS PFD WORN? ___ YES ___ NO What Type?
NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? ___ Swimmer ___ Non-swimmer	DEATH CAUSED BY ___ Drowning ___ Other ___ DISAPPEARANCE	WAS PFD WORN? ___ YES ___ NO What Type?
NAME	ADDRESS	DATE OF BIRTH	WAS VICTIM? ___ Swimmer ___ Non-swimmer	DEATH CAUSED BY ___ Drowning ___ Other ___ DISAPPEARANCE	WAS PFD WORN? ___ YES ___ NO What Type?

INJURED

NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT ___ YES ___ NO
NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT ___ YES ___ NO
NAME	ADDRESS	DATE OF BIRTH	NATURE OF INJURY	MEDICAL TREATMENT ___ YES ___ 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) ___ Operator ___ Owner ___ Investigator ___ Other		DATE SUBMITTED

(Do Not Use) FOR REPORTING AUTHORITY REVIEW (use agency date stamp)

Causes based on (Check one) ___ This report ___ Investigation and this report ___ Investigation ___ Could not be determined	Name of Reviewing Officer	Date Received
Primary Cause of Accident	Secondary Cause of Accident	Reviewed By