

U.S. DEPARTMENT OF HOMELAND SECURITY U. S. COAST GUARD CG-3865 (Rev. 12-06)		BOATING ACCIDENT REPORT		FORM APPROVED OMB NO. 1625-0003 EXPIRATION DATE	
<p>THE OPERATOR OF A VESSEL IS REQUIRED TO SUBMIT A REPORT IN WRITING TO THE STATE REPORTING AUTHORITY WHEN AS A RESULT OF AN OCCURRENCE THAT INVOLVES THE VESSEL OR ITS EQUIPMENT: (1) A PERSON DIES; OR (2) A PERSON IS INJURED AND REQUIRES MEDICAL TREATMENT BEYOND FIRST AID; OR (3) DAMAGE TO THE VESSEL AND OTHER PROPERTY TOTALS \$2,000 OR MORE OR THERE IS A COMPLETE LOSS OF THE VESSEL; OR (4) A PERSON DISAPPEARS FROM THE VESSEL UNDER CIRCUMSTANCES THAT INDICATE DEATH OR INJURY. REPORTING AUTHORITIES MAY REQUIRE REPORTS OF PROPERTY DAMAGE LESS THAN \$ 2,000. THIS REPORT MUST BE SUBMITTED WITHIN 48 HOURS OF THE OCCURRENCE IF A PERSON DIES, IS INJURED, OR DISAPPEARS FROM THE VESSEL. THE REPORT MUST BE SUBMITTED WITHIN 10 DAYS OF THE OCCURRENCE IF THERE IS ONLY DAMAGE TO THE VESSEL AND OTHER PROPERTY. THE OWNER OF THE VESSEL SHALL SUBMIT THIS REPORT TO THE STATE REPORTING AUTHORITY IF THE OPERATOR CANNOT.</p>					
OVERALL ACCIDENT INFORMATION – TO BE COMPLETED BY THE OPERATOR OF THIS VESSEL (VESSEL A)					
STATE		DATE OF ACCIDENT		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	
COUNTY		LOCATION ON THE WATER			
NEAREST CITY OR TOWN		NAME OF BODY OF WATER			
WEATHER FORECASTS / REPORTS AVAILABLE TO AND USED BY THE OPERATOR BEFORE AND DURING USE OF THE VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO					
WEATHER (CHECK ALL THAT APPLY) <input type="checkbox"/> CLEAR <input type="checkbox"/> RAIN <input type="checkbox"/> CLOUDY <input type="checkbox"/> SNOW <input type="checkbox"/> FOG <input type="checkbox"/> HAZY		WATER CONDITIONS <input type="checkbox"/> CALM (WAVES LESS THAN 6") <input type="checkbox"/> CHOPPY (WAVES 6" TO 2') <input type="checkbox"/> ROUGH (WAVES 2' TO 6') <input type="checkbox"/> VERY ROUGH (GREATER THAN 6')		WIND <input type="checkbox"/> NONE <input type="checkbox"/> LIGHT (0 - 12 MPH) <input type="checkbox"/> MODERATE (13 - 24 MPH) <input type="checkbox"/> STRONG (25 - 54 MPH) <input type="checkbox"/> STORM (55 MPH AND OVER)	
		VISIBILITY DAY NIGHT <input type="checkbox"/> GOOD <input type="checkbox"/> <input type="checkbox"/> FAIR <input type="checkbox"/> <input type="checkbox"/> POOR <input type="checkbox"/>		ESTIMATED TEMPERATURE (DEGREES FAHRENHEIT) AIR () WATER () STRONG CURRENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
OPERATOR INFORMATION – TO BE COMPLETED BY THE OPERATOR OF VESSEL A					
NAME		LAST		FIRST	
ADDRESS		STREET		CITY	
TELEPHONE NUMBER ()		DATE OF BIRTH (MO/DAY/YR)		STATE	
EXPERIENCE OPERATING THIS VESSEL		FORMAL INSTRUCTION (TRAINING) COURSE COMPLETED IN BOATING SAFETY		MIDDLE INITIAL	
<input type="checkbox"/> UNDER 10 HOURS <input type="checkbox"/> 10 TO 100 HOURS <input type="checkbox"/> 100 TO 500 HOURS <input type="checkbox"/> OVER 500 HOURS <input type="checkbox"/> OTHER (SPECIFY)		<input type="checkbox"/> NONE <input type="checkbox"/> STATE COURSE <input type="checkbox"/> USCG AUXILIARY <input type="checkbox"/> U.S. POWER SQUADRONS <input type="checkbox"/> INTERNET (SPECIFY) <input type="checkbox"/> OTHER (SPECIFY)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ZIP CODE	
OPERATOR WEARING A USCG APPROVED LIFE JACKET AT THE TIME OF THE ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		OPERATOR WEARING A SAFETY LANYARD (ENGINE SHUT OFF DEVICE) AT THE TIME OF THE ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		AGE IN YEARS	
INFORMATION ASSOCIATED WITH VESSEL A – TO BE COMPLETED BY THE OPERATOR OF VESSEL A					
NUMBER OF PERSONS WHO DIED		NUMBER OF PERSONS DISAPPEARED		WAS VESSEL A TOTAL LOSS <input type="checkbox"/> YES <input type="checkbox"/> NO	
NUMBER OF PERSONS INJURED REQUIRING MEDICAL TREATMENT BEYOND FIRST AID		AMOUNT OF DAMAGE TO THIS VESSEL \$			
AMOUNT OF DAMAGE TO OTHER PROPERTY \$		TOTAL PROPERTY DAMAGE AMOUNT \$			
DESCRIBE VESSEL DAMAGE		DESCRIBE OTHER PROPERTY DAMAGE			
VESSEL REGISTRATION NUMBER		HULL IDENTIFICATION NUMBER (HIN)			
VESSEL NAME		NAME OF VESSEL MANUFACTURER			
VESSEL MODEL		YEAR BUILT		VESSEL LENGTH (FEET AND INCHES)	
VESSEL BEAM WIDTH AT WIDEST POINT (FEET AND INCHES)		DEPTH FROM TRANSOM (STERN) TO KEEL (BOTTOMMOST POINT) OF VESSEL			
VESSEL DOCUMENTATION NUMBER				NUMBER OF PERSONS ON BOARD VESSEL	
RENTED VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		CURRENT VESSEL SAFETY CHECK (VSC) DECAL <input type="checkbox"/> YES <input type="checkbox"/> NO		NUMBER OF PERSONS BEING TOWED	
USCG APPROVED LIFE JACKETS ON BOARD THE VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		OPERATOR ARRESTED DUE TO BOATING UNDER THE INFLUENCE (BUI) FOR THIS ACCIDENT ONLY		FIRE EXTINGUISHERS ON BOARD	
LIFE JACKETS ACCESSIBLE (CAPABLE OF BEING REACHED) <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO OPERATOR BLOOD ALCOHOL CONCENTRATION (BAC) LEVEL		<input type="checkbox"/> YES <input type="checkbox"/> NO USED <input type="checkbox"/> YES <input type="checkbox"/> NO	
NUMBER OF VESSEL OCCUPANTS (OPERATOR AND PASSENGERS) WEARING LIFE JACKETS AT THE TIME OF THE ACCIDENT					

INJURED VICTIMS ASSOCIATED WITH VESSEL A (IF MORE THAN 1 INJURY, ATTACH ADDITIONAL FORMS)			
NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS	STREET	CITY	
AGE OF VICTIM	DATE OF BIRTH	STATE	ZIP CODE
INJURY REQUIRING MEDICAL TREATMENT BEYOND FIRST AID <input type="checkbox"/> YES <input type="checkbox"/> NO WAS INJURED VICTIM ADMITTED TO A HOSPITAL <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF PRIMARY INJURY (CHECK ONE IN EACH COLUMN BELOW)	
WAS A LIFE JACKET WORN BY THE VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO WAS THE LIFE JACKET WORN BY THE VICTIM INFLATABLE <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE OF LIFE JACKET WORN <input type="checkbox"/> TYPE I <input type="checkbox"/> TYPE II <input type="checkbox"/> TYPE III <input type="checkbox"/> TYPE V TYPE IV PERSONAL FLOTATION DEVICE (THROWABLE) USED <input type="checkbox"/> YES <input type="checkbox"/> NO		BODY REGION (CHECK ONE) ___ HEAD / FACE ___ NECK ___ BACK ___ CHEST / ABDOMEN ___ SHOULDER / ARM ___ WRIST / HAND / FINGER ___ PELVIS / HIP ___ KNEE / LEG ___ ANKLE / FOOT / TOE	NATURE OF INJURY (CHECK ONE) ___ ABRASION / CONTUSION (BRUISE) ___ AMPUTATION ___ CARBON MONOXIDE POISONING ___ CONCUSSION / BRAIN INJURY ___ DISLOCATION ___ FRACTURE / BROKEN BONE ___ HEART ATTACK ___ INTERNAL ORGAN INJURY ___ LACERATION / CUT ___ SPINAL CORD INJURY ___ SPRAIN / STRAIN
INJURY CAUSED BY (CHECK ALL THAT APPLY) EXPOSURE TO ELEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH FIXED / FLOATING OBJECT <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH WATER <input type="checkbox"/> YES <input type="checkbox"/> NO BEING STRUCK BY THE VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO BEING STRUCK BY THE PROPELLER <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER (PLEASE SPECIFY):		PRIMARY INJURY: BODY REGION: ___ OTHER (SPECIFY):	PRIMARY INJURY: NATURE OF INJURY: ___ OTHER (SPECIFY):
ALCOHOL USE APPARENT BY THE INJURED VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO BLOOD ALCOHOL CONCENTRATION (BAC) LEVEL:		SECONDARY INJURY: BODY REGION: ___ OTHER (SPECIFY):	SECONDARY INJURY: NATURE OF INJURY: ___ OTHER (SPECIFY):
DRUG USE APPARENT BY THE INJURED VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO SPECIFY THE TYPE (S) OF DRUGS BEING USED:			
VICTIM STATUS AT THE TIME OF THE ACCIDENT <input type="checkbox"/> OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER <input type="checkbox"/> OTHER (SPECIFY)		VICTIM ACTIVITY AT THE TIME OF THE ACCIDENT <input type="checkbox"/> FISHING <input type="checkbox"/> HUNTING <input type="checkbox"/> SCUBA DIVING / SNORKLING <input type="checkbox"/> SWIMMING <input type="checkbox"/> TUBING <input type="checkbox"/> WATERSKIING <input type="checkbox"/> OTHER (SPECIFY):	

DECEASED VICTIMS ASSOCIATED WITH VESSEL A (IF MORE THAN 1 DEATH, ATTACH ADDITIONAL FORMS)			
NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS	STREET	CITY	
AGE OF VICTIM	DATE OF BIRTH	STATE	ZIP CODE
CAUSE OF DEATH <input type="checkbox"/> DROWNING <input type="checkbox"/> TRAUMA <input type="checkbox"/> CARBON MONOXIDE POISONING <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> HYPOTHERMIA <input type="checkbox"/> ELECTROCUTION <input type="checkbox"/> OTHER (SPECIFY)	WAS VICTIM STRUCK BY THE PROPELLER <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A LIFE JACKET WORN BY THE VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO WAS THE LIFE JACKET WORN BY THE VICTIM INFLATABLE <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE OF LIFE JACKET WORN <input type="checkbox"/> TYPE I <input type="checkbox"/> TYPE II <input type="checkbox"/> TYPE III <input type="checkbox"/> TYPE V TYPE IV PERSONAL FLOTATION DEVICE (THROWABLE) USED <input type="checkbox"/> YES <input type="checkbox"/> NO	
	WAS VICTIM STRUCK BY THE VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		
	VICTIM STATUS AT THE TIME OF THE ACCIDENT <input type="checkbox"/> OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER <input type="checkbox"/> OTHER (SPECIFY):	VICTIM ACTIVITY AT THE TIME OF THE ACCIDENT <input type="checkbox"/> FISHING <input type="checkbox"/> HUNTING <input type="checkbox"/> SCUBA DIVING / SNORKLING <input type="checkbox"/> SWIMMING <input type="checkbox"/> TUBING <input type="checkbox"/> WATERSKIING <input type="checkbox"/> OTHER (SPECIFY)	
DISAPPEARANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	ALCOHOL USE APPARENT BY THE VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO BLOOD ALCOHOL CONCENTRATION (BAC) LEVEL:	DRUG USE APPARENT BY THE VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE(S) OF DRUGS BEING USED:	

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED (SEQUENCE OF EVENTS) AND CONTRIBUTING FACTORS. INCLUDE FAILURE OF MACHINERY OR EQUIPMENT. INCLUDE A DIAGRAM AND 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 PERSONAL FLOATATION DEVICES (PFDS). PLEASE DO NOT LIST ANY PERSONAL IDENTIFIERS IN THIS SECTION -- SUCH AS NAMES OF INDIVIDUALS, TELEPHONE NUMBERS, STREET ADDRESSES, ETC. REFER TO INDIVIDUALS AS OPERATOR A, OPERATOR B, VICTIM 1, VICTIM 2, ETC. AND TO THE VESSEL(S) INVOLVED AS VESSEL A, VESSEL B, ETC. FOR EXAMPLE: OPERATOR OF VESSEL (A) DID NOT HAVE A PROPER LOOKOUT AND RAN INTO VESSEL (B) INJURING VICTIMS (1) AND (2) ON VESSEL (B).

WITNESSES FOR THIS ACCIDENT (IF MORE THAN ONE - LIST ON A SEPARATE SHEET)

NAME	LAST	FIRST	TELEPHONE NUMBER ()	
ADDRESS	STREET	CITY	STATE	ZIP CODE

OWNERS OF PROPERTY INVOLVED (IF MORE THAN ONE - LIST ON A SEPARATE SHEET)

NAME	LAST	FIRST	TELEPHONE NUMBER ()	
ADDRESS	STREET	CITY	STATE	ZIP CODE

OWNER INFORMATION FOR VESSEL A

NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS	STREET	CITY	
TELEPHONE NUMBER ()		STATE	ZIP CODE

PERSON SUBMITTING THIS REPORT FOR VESSEL A

STATUS OF PERSON COMPLETING THIS REPORT OPERATOR OWNER

OTHER (OPERATOR AND OWNER ARE UNABLE TO COMPLETE THIS REPORT) -- SPECIFY WHO IS COMPLETING THIS REPORT:

NAME	LAST	FIRST	TELEPHONE NUMBER ()	
ADDRESS	STREET	CITY	STATE	ZIP CODE
SIGNATURE			DATE SUBMITTED	

OPERATOR OR OWNER OF THE OTHER VESSEL (VESSEL B) INVOLVED IN THE ACCIDENT

EACH VESSEL OPERATOR OR OWNER IS REQUIRED TO FILE A SEPARATE AND COMPLETE REPORT

NAME	LAST	FIRST	TELEPHONE NUMBER ()	
ADDRESS	STREET	CITY	STATE	ZIP CODE

FOR STATE AGENCY USE ONLY

OFFICIAL	LAST NAME	FIRST	TELEPHONE NUMBER ()	
PRIMARY CAUSE OF THE ACCIDENT		SECONDARY CAUSE OF THE ACCIDENT		
SIGNATURE OF REVIEWING OFFICIAL			DATE REVIEWED	

An Agency may not conduct or sponsor and a person is not required to respond to an information collection, unless it displays a currently valid OMB Control Number. The Coast Guard estimates that the average burden for this report form is 30 minutes. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Commandant (CG-3PCB), U.S. Coast Guard, Washington, DC 20593-0001 or Office of Management and Budget, Paperwork Reduction Project (1625-0003), Washington, DC 20593.