

**AUSTIN PEAY STATE UNIVERSITY
GROUND ACCIDENT/INCIDENT REPORTING FORM**

Incident Identification

Date of Accident:	Time of Accident:	Period of Day: <input type="checkbox"/> Day <input type="checkbox"/> Night
Location of Accident:		Type Location:
Reporter's Name:		Reporter's Contact Number:
Activity:	<i>Briefly describe the activity being performed:</i>	

Aircraft/Equipment/Personnel Involved

Was an aircraft involved in the incident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Make/Model:	Tail Number:
Was any equipment involved in the incident: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Briefly list any equipment involved:</i>	
Was any personnel involved in the incident: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>List personnel below:</i>	
Person 1		
Name:	Date of Birth:	A Number:
Address:		Contact Number:
Were you injured: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Briefly describe injury:</i>	
Days Hospitalized:	Workdays Lost:	Workdays Restricted:
Worker's Compensation Form Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Form was Filed:	

Person 2		
Name:	Date of Birth:	A Number:
Address:		Contact Number:
Were you injured: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Briefly describe injury:</i>	
Days Hospitalized:	Workdays Lost:	Workdays Restricted:
Worker's Compensation Form Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Form was Filed:	

Action Taken

Initial Response: <i>(What was done immediately after the incident)</i>
Witness Information: <i>(Names and contact information of any witnesses)</i>
Further Actions: <i>(List any additional actions taken or planned to investigate or resolve the issue - COMPLETED BY AVIATION SAFETY COORDINATOR)</i>