

DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-3865		BOATING ACCIDENT REPORT		FORM APPROVED OMB NO. 1625-0003	
		CASE NUMBER		[ENA - Emergency Department]	
THE OPERATOR OF A VESSEL THAT IS BEING USED FOR RECREATIONAL PURPOSES IS REQUIRED TO FILE THIS REPORT IMMEDIATELY TO THE REPORTING AUTHORITY IN THE STATE WHERE THE ACCIDENT OCCURRED WHENEVER AN ACCIDENT RESULTS IN: LOSS OF LIFE OR DISAPPEARANCE OF A PERSON; AN INJURY WHICH REQUIRES MEDICAL TREATMENT BEYOND FIRST AID; PROPERTY DAMAGE OF \$2,000 OR MORE; OR COMPLETE LOSS OF THE VESSEL. STATE AUTHORITIES MAY REQUIRE REPORTS OF PROPERTY DAMAGE LESS THAN 2,000. THE OWNER OF THE VESSEL SHALL FILE THE REPORT IF THE OPERATOR CANNOT.					
COMPLETE ALL BLOCKS (INDICATE THOSE NOT APPLICABLE BY "NA")					
ACCIDENT DATA					
NUMBER OF PERSONS DECEASED		NUMBER INJURED BEYOND FIRST AID		NUMBER DISAPPEARED	
NUMBER OF VESSELS INVOLVED		TOTAL PROPERTY DAMAGE AMOUNT \$		WAS VESSEL A TOTAL LOSS <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE OF ACCIDENT		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		LATITUDE	
LOCATION NAME		STATE		COUNTY	
				LONGITUDE	
NAME OF BODY OF WATER			NEAREST CITY OR TOWN		ALCOHOL INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO
NUMBER OF MILES OFF-SHORE _____ <input type="checkbox"/> ATLANTIC OCEAN <input type="checkbox"/> GULF OF MEXICO <input type="checkbox"/> PACIFIC OCEAN			REPORT STATUS <input type="checkbox"/> STATE REPORTABLE <input type="checkbox"/> USCG REPORTABLE <input type="checkbox"/> RECREATIONAL <input type="checkbox"/> COMMERCIAL <input type="checkbox"/> USCG NON-REPORTABLE		
WEATHER (CHECK ALL APPLICABLE) <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') <input type="checkbox"/> STRONG / SWIFT CURRENT		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)	
		TEMPERATURE AIR (____) °F WATER (____) °F		VISIBILITY DAY <input type="checkbox"/> NIGHT <input type="checkbox"/> <input type="checkbox"/> GOOD <input type="checkbox"/> <input type="checkbox"/> FAIR <input type="checkbox"/> <input type="checkbox"/> POOR <input type="checkbox"/>	
OPERATOR / OWNER INFORMATION					
OPERATOR NAME		LAST		FIRST	
				MIDDLE INITIAL	
ADDRESS		STREET		CITY	
				STATE	
TELEPHONE NUMBER (____) _____		DATE OF BIRTH (MO/DAY/YR)		AGE IN YEARS	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		OPERATOR EXPERIENCE WITH THIS VESSEL <input type="checkbox"/> UNDER 10 HOURS <input type="checkbox"/> OVER 500 HOURS <input type="checkbox"/> 10 TO 100 HOURS <input type="checkbox"/> OTHER <input type="checkbox"/> 100 TO 500 HOURS		OPERATOR INSTRUCTION IN BOATING SAFETY <input type="checkbox"/> STATE COURSE <input type="checkbox"/> INTERNET COURSE <input type="checkbox"/> NONE <input type="checkbox"/> USCG AUXILIARY (SPECIFY) <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> US POWER SQUADRONS	
OWNER NAME		LAST		FIRST	
				MIDDLE INITIAL	
ADDRESS		STREET		CITY	
				STATE	
TELEPHONE NUMBER (____) _____				ZIP	
VESSEL A (THIS VESSEL)					
NUMBER DECEASED FOR THIS VESSEL _____		OPERATOR DECEASED <input type="checkbox"/> YES <input type="checkbox"/> NO		NUMBER INJURED BEYOND FIRST AID FOR THIS VESSEL _____	
AMOUNT OF DAMAGE FOR THIS VESSEL \$ _____		DESCRIBE VESSEL DAMAGE			
AMOUNT OF DAMAGE TO OTHER PROPERTY \$ _____		DESCRIBE OTHER PROPERTY DAMAGE			
VESSEL REGISTRATION NUMBER			STATE		VESSEL NAME
HULL IDENTIFICATION NUMBER (HIN)				VESSEL MODEL	
VESSEL DOCUMENTATION NUMBER			YEAR BUILT		VESSEL LENGTH IN FEET AND INCHES
NAME OF VESSEL MANUFACTURER			VESSEL SAFETY CHECK (VSC) NUMBER		
RENTED VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		OPERATOR LIVED AT VESSEL OWNER'S RESIDENCE <input type="checkbox"/> YES <input type="checkbox"/> NO VESSEL OWNER WAS <input type="checkbox"/> OCCUPANT <input type="checkbox"/> OPERATOR <input type="checkbox"/> NOT PRESENT			BUI ARREST <input type="checkbox"/> YES <input type="checkbox"/> NO OPERATOR BAC _____
COAST GUARD (USCG) APPROVED PERSONAL FLOTATION DEVICES (PFDS) VESSEL EQUIPPED WITH USCG APPROVED PFDS <input type="checkbox"/> YES <input type="checkbox"/> NO USCG APPROVED PFDS ACCESSIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO		OPERATOR WEARING USCG PFD <input type="checkbox"/> YES <input type="checkbox"/> NO USED SAFETY LANYARD <input type="checkbox"/> YES <input type="checkbox"/> NO			FIRE EXTINGUISHERS ON BOARD <input type="checkbox"/> YES <input type="checkbox"/> NO USED <input type="checkbox"/> YES <input type="checkbox"/> NO

ACCIDENT DESCRIPTORS

[ENA – Emergency Department]

- | | | |
|---|---|--|
| <input type="checkbox"/> BOAT FOUND CAPSIZED | <input type="checkbox"/> BOAT STRUCK BY LIGHTNING | <input type="checkbox"/> BOAT FOUND UPRIGHT, DRIFTING, OCCUPANTS DISAPPEARED |
| <input type="checkbox"/> COLLISION WITH COMMERCIAL VESSEL | <input type="checkbox"/> VICTIM STRUCK BY BOOM | <input type="checkbox"/> VICTIM ENTANGLED IN LINES |
| <input type="checkbox"/> PARASAILING ACCIDENT | <input type="checkbox"/> RUNAWAY BOAT | |

ESTIMATED NUMBER OF DAYS VESSEL USED THIS YEAR	TYPICAL NUMBER OF HOURS VESSEL USED EACH DAY THIS YEAR
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TYPICAL NUMBER OF PERSONS (INCLUDING YOURSELF) ON BOARD VESSEL EACH DAY THIS YEAR

OTHER PEOPLE ON BOARD THIS VESSEL (IF MORE THAN 2 PEOPLE, ATTACH ADDITIONAL FORMS)

NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS	STREET	CITY	
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	STATE	ZIP
WAS PFD WORN	PFD WORN PRIOR TO ACCIDENT	PFD WORN AS A RESULT OF ACCIDENT	WAS PFD WORN INFLATABLE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS	STREET	CITY	
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	STATE	ZIP
WAS PFD WORN	PFD WORN PRIOR TO ACCIDENT	PFD WORN AS A RESULT OF ACCIDENT	WAS PFD WORN INFLATABLE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

IF TWO (2) OR MORE VESSELS WERE INVOLVED – DID THE OPERATOR (S) OF THE VESSEL (S) FILE A REPORT YES NO

VESSEL B (SECOND VESSEL – EACH OPERATOR IS REQUIRED TO FILE A SEPARATE REPORT)

OPERATOR NAME	LAST	FIRST	MIDDLE INITIAL
VESSEL REGISTRATION NUMBER			STATE
PROPERTY DAMAGE FOR THIS VESSEL (S) AND CONTENTS \$	DESCRIBE PROPERTY DAMAGE _____		

WITNESSES NOT ON THIS VESSEL (IF MORE THAN 2 LIST ON SEPARTATE SHEET)

NAME	LAST	FIRST	PHONE NO. (____) _____
ADDRESS	STREET	CITY	STATE ZIP
NAME	LAST	FIRST	PHONE NO. (____) _____
ADDRESS	STREET	CITY	STATE ZIP

PERSON COMPLETING REPORT

NAME	LAST	FIRST	PHONE NO. (____) _____
ADDRESS	STREET	CITY	STATE ZIP

STATUS OF PERSON COMPLETING REPORT OPERATOR OWNER INVESTIGATOR OTHER (SPECIFY)

SIGNATURE	DATE SUBMITTED
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FOR AGENCY USE ONLY

CAUSES BASED ON (CHECK ONE) THIS REPORT INVESTIGATION INVESTIGATION AND THIS REPORT OTHER (SPECIFY)

NAME OF REVIEWING STATE REPORTING AUTHORITY	DATE RECEIVED		
SIGNATURE OF REVIEWING OFFICIAL	DATE REVIEWED		
INVESTIGATOR'S NAME	LAST	FIRST	PHONE NO. (____) _____
PRIMARY CAUSE	SECONDARY CAUSE	TERTIARY CAUSE	

ACCIDENT DESCRIPTION

[ENA – Emergency Department]

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).

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 (G-OPB-1), U.S. Coast Guard, Washington, DC 20593-0001.

INJURED VICTIMS (IF MORE THAN 2 INJURIES, ATTACH ADDITIONAL FORMS) [ENA – Emergency Department]

VICTIM 1 NAME		LAST	FIRST	MIDDLE INITIAL																		
ADDRESS OF VICTIM 1		STREET	CITY																			
AGE OF VICTIM		DATE OF BIRTH	STATE	ZIP																		
MEDICAL TREATMENT BEYOND FIRST AID? <input type="checkbox"/> YES <input type="checkbox"/> NO ADMITTED TO HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY (CHECK ALL THAT APPLY)																				
WAS PFD WORN? <input type="checkbox"/> YES <input type="checkbox"/> NO PRIOR TO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO AS A RESULT OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		<table style="width:100%; border:none;"> <tr> <td style="width:30%;"></td> <td style="width:40%; text-align:center;">PRIMARY</td> <td style="width:30%; text-align:center;">SECONDARY</td> </tr> <tr> <td>TYPE OF PFD WORN</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> TYPE I</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> TYPE II</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> TYPE III</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> TYPE V</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>				PRIMARY	SECONDARY	TYPE OF PFD WORN			<input type="checkbox"/> TYPE I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TYPE II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TYPE III	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TYPE V	<input type="checkbox"/>	<input type="checkbox"/>
	PRIMARY	SECONDARY																				
TYPE OF PFD WORN																						
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<input type="checkbox"/> TYPE V	<input type="checkbox"/>	<input type="checkbox"/>																				
PFD WORN WAS <input type="checkbox"/> INHERENTLY BUOYANT <input type="checkbox"/> INFLATABLE		AMPUTATION BACK INJURY BROKEN BONE(S) BURNS CARBON MONOXIDE POISONING CONTUSION DISLOCATION ELECTROCUTION HEAD INJURY HYPOTHERMIA INTERNAL INJURIES LACERATION NECK INJURY SHOCK SPINAL INJURY SPRAIN / STRAIN TEETH																				
ALCOHOL USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES BAC _____		USCG PFD APPROVAL NUMBER 160. _____																				
INJURY CAUSED BY (CHECK ALL THAT APPLY)																						
IMPACT WITH VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH WATER <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH FIXED / FLOATING OBJECT <input type="checkbox"/> YES <input type="checkbox"/> NO STRUCK BY VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO STRUCK BY PROPULSION SYSTEM <input type="checkbox"/> YES <input type="checkbox"/> NO EXPOSURE TO ELEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO																						
INJURED STATUS																						
<input type="checkbox"/> OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER																						
VICTIM 2 NAME		LAST	FIRST	MIDDLE INITIAL																		
ADDRESS OF VICTIM 2		STREET	CITY																			
AGE OF VICTIM		DATE OF BIRTH	STATE	ZIP																		
MEDICAL TREATMENT BEYOND FIRST AID? <input type="checkbox"/> YES <input type="checkbox"/> NO ADMITTED TO HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY (CHECK ALL THAT APPLY)																				
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	PRIMARY	SECONDARY																				
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PFD WORN WAS <input type="checkbox"/> INHERENTLY BUOYANT <input type="checkbox"/> INFLATABLE		AMPUTATION BACK INJURY BROKEN BONE(S) BURNS CARBON MONOXIDE POISONING CONTUSION DISLOCATION ELECTROCUTION HEAD INJURY HYPOTHERMIA INTERNAL INJURIES LACERATION NECK INJURY SHOCK SPINAL INJURY SPRAIN / STRAIN TEETH																				
ALCOHOL USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES BAC _____		USCG PFD APPROVAL NUMBER 160. _____																				
INJURY CAUSED BY (CHECK ALL THAT APPLY)																						
IMPACT WITH VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH WATER <input type="checkbox"/> YES <input type="checkbox"/> NO IMPACT WITH FIXED / FLOATING OBJECT <input type="checkbox"/> YES <input type="checkbox"/> NO STRUCK BY VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO STRUCK BY PROPULSION SYSTEM <input type="checkbox"/> YES <input type="checkbox"/> NO EXPOSURE TO ELEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO																						
INJURED STATUS																						
<input type="checkbox"/> OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER																						

DECEASED VICTIMS (IF MORE THAN 2 FATALITIES, ATTACH ADDITIONAL FORMS) [ENA – Emergency Department]

VICTIM 1 NAME		LAST	FIRST	MIDDLE INITIAL	
ADDRESS OF VICTIM 1		STREET	CITY		
AGE OF VICTIM		DATE OF BIRTH	STATE	ZIP	
ALCOHOL USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES BAC _____		DRUG USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE _____			
CAUSE OF DEATH <input type="checkbox"/> CARBON MONOXIDE POISONING <input type="checkbox"/> DROWNING <input type="checkbox"/> HYPOTHERMIA <input type="checkbox"/> TRAUMA <input type="checkbox"/> ELECTROCUTION <input type="checkbox"/> OTHER (SPECIFY) _____		VICTIM ACTIVITY <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"/> WATER SKIING <input type="checkbox"/> OTHER (SPECIFY) _____		PFD WORN <input type="checkbox"/> YES <input type="checkbox"/> NO PFD WORN WAS <input type="checkbox"/> INHERENTLY BUOYANT <input type="checkbox"/> INFLATABLE PFD USED – BUT NOT WORN <input type="checkbox"/> YES TYPE _____ <input type="checkbox"/> NO PFD WAS NOT WORN AND NOT USED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	TYPE OF PFD WORN <input type="checkbox"/> TYPE I <input type="checkbox"/> TYPE II <input type="checkbox"/> TYPE III <input type="checkbox"/> TYPE V PFD PERFORMANCE <input type="checkbox"/> SUCCESSFUL <input type="checkbox"/> FAILED <input type="checkbox"/> IMPROPER WEAR / USE COMMENTS
VICTIM STRUCK BY VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		VICTIM STRUCK BY PROPULSION UNIT <input type="checkbox"/> YES <input type="checkbox"/> NO		USCG PFD APPROVAL NUMBER 160. _____	
DISAPPEARANCE <input type="checkbox"/> YES <input type="checkbox"/> NO		DECEASED STATUS <input type="checkbox"/> OPERATOR <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER			
PHYSICAL CONDITION			VICTIM SWIMMING ABILITY		
<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NORMAL <input type="checkbox"/> ILL <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> UNDER INFLUENCE OF ALCOHOL / DRUGS <input type="checkbox"/> OTHER (SPECIFY) – _____			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		

VICTIM 2 NAME		LAST	FIRST	MIDDLE INITIAL	
ADDRESS OF VICTIM 2		STREET	CITY		
AGE OF VICTIM		DATE OF BIRTH	STATE	ZIP	
ALCOHOL USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES BAC _____		DRUG USE APPARENT <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE _____			
CAUSE OF DEATH <input type="checkbox"/> CARBON MONOXIDE POISONING <input type="checkbox"/> DROWNING <input type="checkbox"/> HYPOTHERMIA <input type="checkbox"/> TRAUMA <input type="checkbox"/> ELECTROCUTION <input type="checkbox"/> OTHER (SPECIFY) _____		VICTIM ACTIVITY <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"/> WATER SKIING <input type="checkbox"/> OTHER (SPECIFY) _____		PFD WORN <input type="checkbox"/> YES <input type="checkbox"/> NO PFD WORN WAS <input type="checkbox"/> INHERENTLY BUOYANT <input type="checkbox"/> INFLATABLE PFD USED – BUT NOT WORN <input type="checkbox"/> YES TYPE _____ <input type="checkbox"/> NO PFD WAS NOT WORN AND NOT USED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	TYPE OF PFD WORN <input type="checkbox"/> TYPE I <input type="checkbox"/> TYPE II <input type="checkbox"/> TYPE III <input type="checkbox"/> TYPE V PFD PERFORMANCE <input type="checkbox"/> SUCCESSFUL <input type="checkbox"/> FAILED <input type="checkbox"/> IMPROPER WEAR / USE COMMENTS
VICTIM STRUCK BY VESSEL <input type="checkbox"/> YES <input type="checkbox"/> NO		VICTIM STRUCK BY PROPULSION UNIT <input type="checkbox"/> YES <input type="checkbox"/> NO		USCG PFD APPROVAL NUMBER 160. _____	
DISAPPEARANCE <input type="checkbox"/> YES <input type="checkbox"/> NO		DECEASED STATUS <input type="checkbox"/> OPERATOR <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> PASSENGER <input type="checkbox"/> SWIMMER <input type="checkbox"/> WATER SKIER			
PHYSICAL CONDITION			VICTIM SWIMMING ABILITY		
<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NORMAL <input type="checkbox"/> ILL <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> UNDER INFLUENCE OF ALCOHOL / DRUGS <input type="checkbox"/> OTHER (SPECIFY) – _____			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		