

BOATING ACCIDENT REPORT

PREVIOUS EDITIONS ARE OBSOLETE

Revised 10/2020

STATE OF CONNECTICUT
DEPARTMENT OF ENERGY & ENVIRONMENTAL PROTECTION
BUREAU OF OUTDOOR RECREATION
BOATING DIVISION

P.O. BOX 280, OLD LYME CT 06371-0280

E-mail: deep.boating@ct.gov



POLICE DEPARTMENT NAME AND CASE NO. (If any)

The operator of a vessel used for recreational purposes is required to file a report in writing within 48 hours whenever an accident results in loss of life, disappearance from a vessel or injury which requires medical attention beyond first aid. If total damage to all property is in excess of \$500, a report must be filed within 5 days. Reports shall be submitted to the commissioner of Energy and Environmental Protection at the above address. If the operator is unable to report the accident, the boat owner or survivor of the accident should prepare the report. Any person violating these requirements is subject to the penalties prescribed by law.

YOUR VESSEL INFORMATION (Vessel # 1) COMPLETE ALL BLOCKS (Indicate those not applicable by "N/A")

NAME AND ADDRESS OF OPERATOR		AGE	D.O.B.	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	OPERATOR'S EXPERIENCE ON THIS VESSEL <input type="checkbox"/> Under 20 hours <input type="checkbox"/> 100 to 500 hours <input type="checkbox"/> 20 to 100 hours <input type="checkbox"/> Over 500 hours <input type="checkbox"/> unknown		OPERATOR'S FORMAL BOATING INSTRUCTION (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> State Course <input type="checkbox"/> USCG Aux. Course <input type="checkbox"/> US Power Squadrons <input type="checkbox"/> Other _____ <input type="checkbox"/> unknown	
OPERATOR'S PHONE NUMBER				OPERATOR'S EXPERIENCE ON OTHER VESSELS <input type="checkbox"/> Under 20 hours <input type="checkbox"/> 100 to 500 hours <input type="checkbox"/> 20 to 100 hours <input type="checkbox"/> Over 500 hours <input type="checkbox"/> unknown				
OPERATOR'S SAFE BOATING OR PWC CERTIFICATE #								
NAME AND ADDRESS OF OWNER <input type="checkbox"/> SAME AS ABOVE				RENTED BOAT? <input type="checkbox"/> Y <input type="checkbox"/> N	NUMBER OF PEOPLE ON BOARD	NUMBER OF PEOPLE BEING TOWED <i>ex. skier, tuber</i>		

REGISTRATION NUMBER	STATE	MAKE	MODEL & YEAR	HULL IDENTIFICATION NUMBER		BOAT NAME			
TYPE OF VESSEL <input type="checkbox"/> Air Boat <input type="checkbox"/> Paddlecraft <input type="checkbox"/> Auxiliary Sail <input type="checkbox"/> PWC <input type="checkbox"/> Cabin Motorboat <input type="checkbox"/> Pontoon Boat <input type="checkbox"/> Houseboat <input type="checkbox"/> Rowboat <input type="checkbox"/> Inflatable Boat <input type="checkbox"/> Sail ONLY <input type="checkbox"/> Open Motorboat <input type="checkbox"/> Other		HULL MATERIAL <input type="checkbox"/> Aluminum <input type="checkbox"/> Fiberglass <input type="checkbox"/> Rubber/Vinyl/Canvas <input type="checkbox"/> Plastic <input type="checkbox"/> Steel <input type="checkbox"/> Wood <input type="checkbox"/> Other		ENGINE TYPE <input type="checkbox"/> Inboard <input type="checkbox"/> Outboard <input type="checkbox"/> Rubber Drive <input type="checkbox"/> Sterndrive <input type="checkbox"/> Other	PROPULSION <input type="checkbox"/> Propeller <input type="checkbox"/> Manual <input type="checkbox"/> Water Jet <input type="checkbox"/> Sail <input type="checkbox"/> Air Thrust <input type="checkbox"/> Other	ENGINES No. _____ Total HP _____	LENGTH ft. _____	BEAM (Width) ft. _____	DEPTH FROM TRANSOM TO KEEL ft. _____
FUEL TYPE <input type="checkbox"/> Gasoline <input type="checkbox"/> Electric <input type="checkbox"/> Diesel <input type="checkbox"/> Other									

SAFETY EQUIPMENT ON VESSEL

PERSONAL FLOTATION DEVICES Number of Life Jackets Onboard: _____	Were They USCG approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were They Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were They Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	HAS VESSEL HAD A VESSEL SAFETY CHECK WITHIN THE PAST YEAR? <input type="checkbox"/> Yes <input type="checkbox"/> No	Given A VSC Sticker? <input type="checkbox"/> Yes <input type="checkbox"/> No
FIRE EXTINGUISHERS Number of Fire Extinguishers and Type: _____	Were They Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	ORGANIZATION THAT CONDUCTED THE VESSEL SAFETY CHECK <input type="checkbox"/> USCG Auxiliary <input type="checkbox"/> US Power Squadrons <input type="checkbox"/> DEEP <input type="checkbox"/> Other _____			

ACCIDENT DETAILS

DATE OF ACCIDENT	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	# VESSELS INVOLVED	NAME OF WATER BODY	EXACT LOCATION <i>If possible, provide Latitude and Longitude</i>	NEAREST TOWN		
WEATHER CONDITIONS <input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Cloudy <input type="checkbox"/> Hazy <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Other	WAVE CONDITIONS <input type="checkbox"/> Calm (Under 6in.) <input type="checkbox"/> Choppy (6in. - 2ft.) <input type="checkbox"/> Rough (2ft. - 6ft.) <input type="checkbox"/> Very Rough (over 6ft.)	WIND <input type="checkbox"/> None <input type="checkbox"/> Light (0 - 12 mph) <input type="checkbox"/> Moderate (12- 25 mph) <input type="checkbox"/> Strong (25- 55 mph) <input type="checkbox"/> Stormy (over 55 mph)	VISIBILITY <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Fair	EST. AIR TEMP °F _____	STRONG CURRENT? <input type="checkbox"/> Yes <input type="checkbox"/> No CONGESTED WATERS? <input type="checkbox"/> Yes <input type="checkbox"/> No HAZARDOUS WATERS? <input type="checkbox"/> Yes <input type="checkbox"/> No	WEATHER ENCOUNTERED? <input type="checkbox"/> was as forecast <input type="checkbox"/> not as forecast <input type="checkbox"/> no forecast obtained <input type="checkbox"/> None <input type="checkbox"/> Other	
ESTIMATED SPEED <input type="checkbox"/> 0 - 10 mph <input type="checkbox"/> None <input type="checkbox"/> 11 -20 mph <input type="checkbox"/> 21 - 40 mph <input type="checkbox"/> Over 40 mph		OPERATOR/PASSENGER ACTIVITIES (Check all applicable) <input type="checkbox"/> Recreational <input type="checkbox"/> Commercial <input type="checkbox"/> Fishing <input type="checkbox"/> Hunting <input type="checkbox"/> White Water Activity <input type="checkbox"/> Tubing <input type="checkbox"/> Waterskiing <input type="checkbox"/> Starting Engine <input type="checkbox"/> Making Repairs <input type="checkbox"/> Relaxing <input type="checkbox"/> Other: (list) _____		ACCIDENT EVENTS (Check all applicable) <input type="checkbox"/> Collision w/ Recreational Vessel <input type="checkbox"/> Collision w/ Commercial Vessel <input type="checkbox"/> Collision w/ Fixed Object <input type="checkbox"/> Collision w/ Floating Object <input type="checkbox"/> Collision w/Submerged Object <input type="checkbox"/> Sinking <input type="checkbox"/> Grounding <input type="checkbox"/> Capsizing <input type="checkbox"/> Flooding / Swamping <input type="checkbox"/> Fire / Explosion (Fuel) <input type="checkbox"/> Fire / Explosion (Non- Fuel) <input type="checkbox"/> Person Electrocuted <input type="checkbox"/> Carbon Monoxide Exposure <input type="checkbox"/> Person Struck By Vessel <input type="checkbox"/> Person Fell Overboard <input type="checkbox"/> Person Struck By Propeller <input type="checkbox"/> Sudden Medical Condition <input type="checkbox"/> Person Fell On/Within Vessel <input type="checkbox"/> Mishap of Skier, Tuber, wake brd <input type="checkbox"/> Person Left Vessel Voluntarily <input type="checkbox"/> Person Ejected from Vessel <input type="checkbox"/> Other (describe) _____		CONTRIBUTING FACTORS (check all applicable) <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use <input type="checkbox"/> Hazardous Waters <input type="checkbox"/> Excessive Speed <input type="checkbox"/> Improper Anchoring <input type="checkbox"/> Improper Loading <input type="checkbox"/> Overloading <input type="checkbox"/> Improper Lookout <input type="checkbox"/> Operator Inattention <input type="checkbox"/> Operator Inexperience <input type="checkbox"/> Language Barrier <input type="checkbox"/> Navigation Rules Violation <input type="checkbox"/> Failure to Vent <input type="checkbox"/> Ignition of Fuel or Vapors <input type="checkbox"/> Machinery Failure (check applicable below) <input type="checkbox"/> Engine <input type="checkbox"/> Electrical Sys. <input type="checkbox"/> Fuel System <input type="checkbox"/> Radio <input type="checkbox"/> Throttle <input type="checkbox"/> Shift <input type="checkbox"/> People on Gunwale/Bow/Transom <input type="checkbox"/> Force of Wake/Wave <input type="checkbox"/> Heavy Weather <input type="checkbox"/> Sharp Turn <input type="checkbox"/> Hull Failure <input type="checkbox"/> Starting in Gear <input type="checkbox"/> Restricted Vision (ex., fog) <input type="checkbox"/> Missing/Inadequate Aids to Nav. <input type="checkbox"/> Inadequate On-Board Nav. Lights <input type="checkbox"/> Dam/Lock <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> Equipment Failure (check applicable below) <input type="checkbox"/> Auxiliary Equipment <input type="checkbox"/> Fire Extinguisher <input type="checkbox"/> Sound Equip. (ex. horn) <input type="checkbox"/> Other: _____	

INJURED / MISSING / DECEASED

NAME AND ADDRESS OF VICTIM	AGE	D.O.B.	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	ONBOARD VESSEL	WAS A PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Treatment Beyond 1st Aid <input type="checkbox"/> Victim Was Hospitalized
DEATH CAUSED BY: (If applicable) <input type="checkbox"/> Drowning <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____			MISSING <input type="checkbox"/> Y <input type="checkbox"/> N	TYPE OF INJURY		LOCATION OF INJURY

NAME AND ADDRESS OF VICTIM	AGE	D.O.B.	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	ONBOARD VESSEL	WAS A PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Treatment Beyond 1st Aid <input type="checkbox"/> Victim Was Hospitalized
DEATH CAUSED BY: (If applicable) <input type="checkbox"/> Drowning <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____			MISSING <input type="checkbox"/> Y <input type="checkbox"/> N	TYPE OF INJURY		LOCATION OF INJURY

NOTE: If more space is needed to list information concerning Injured / Missing / Deceased persons please attach a separate page.

PROPERTY DAMAGE

PROPERTY DAMAGE ESTIMATE	PROPERTY DAMAGE DESCRIPTION
Vessel #1 \$ _____	<input type="checkbox"/> Vessel Was A Loss. \$ _____ Vessel's Value
Vessel #2 \$ _____	
Other Property (not vessel) \$ _____	

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED (Include a sequence of events and what in your opinion caused the accident. Include or attach a diagram if needed. Continue on additional sheets of paper if necessary.)

ALCOHOL / DRUG USE

Did the operator consume any alcohol or do drugs before or during the operation of the vessel?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Lot	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drugs	<input type="checkbox"/> Both
Did any of the passengers consume any alcohol or do drugs before or during the operation of the vessel?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Lot	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drugs	<input type="checkbox"/> Both
Was there any alcohol or drugs onboard during the operation of the vessel?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Lot	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drugs	<input type="checkbox"/> Both
If this accident involved more than one vessel, was there any indication that the operator of the other vessel(s) had consumed any alcohol or done drugs?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Lot	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drugs	<input type="checkbox"/> Both

OTHER KEY CONTACT INFORMATION *(If more than 2 vessels / property were involved, please attach a separate sheet of paper with this information.)*

<input type="checkbox"/> Other Vessel Operator	<input type="checkbox"/> Other Vessel Owner	<input type="checkbox"/> Owner of other damaged property	<input type="checkbox"/> Passenger on your vessel	<input type="checkbox"/> Witness
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NAME AND ADDRESS	PHONE NUMBER
	OTHER VESSEL REGISTRATION (if applicable)

<input type="checkbox"/> Other Vessel Operator	<input type="checkbox"/> Other Vessel Owner	<input type="checkbox"/> Owner of other damaged property	<input type="checkbox"/> Passenger on your vessel	<input type="checkbox"/> Witness
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NAME AND ADDRESS	PHONE NUMBER
	OTHER VESSEL REGISTRATION (if applicable)

SIGNATURE

The information on this form is certified under penalty of false statement to be true and complete.

X _____ Signature of person completing this report	_____ Date	_____ Printed name of person completing this report
_____ Address (Street, Town, State)	_____ Phone	

INVOLVEMENT: Operator Owner Witness: Other: _____