



BOATING ACCIDENT REPORT

The operator of a vessel involved in an accident is required to file a report in writing whenever an accident results in loss of life, loss of consciousness, medical treatment or disability in excess of 24 hours or property damage in excess of \$500. Reports in death and injury cases must be submitted within 48 hours; reports in other cases are required within 10 days. All reports shall be submitted to the Nevada Division of Wildlife, 1100 Valley Road, Reno, Nevada 89512, and shall include a full description of the collision, accident or other casualty. (NRS 488.550, NAC 488.440 and 488.445.)

COMPLETE ALL BLOCKS (Indicate Those Not Applicable by "NA")						
ACCIDENT DATA						
DATE OF ACCIDENT		TIME AM PM	NAME OF BODY OF WATER		LOCATION (Give location precisely)	
NO. OF VESSELS INVOLVED		NEAREST CITY OR TOWN		COUNTY	STATE	
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 inches) <input type="checkbox"/> Choppy (Waves 6 inches to 2 feet) <input type="checkbox"/> Rough (Waves 2 feet to 6 feet) <input type="checkbox"/> Very Rough (Greater than 6 feet) <input type="checkbox"/> Strong Current		TEMPERATURE (Estimate) Air.....°F Water.....°F	WIND <input type="checkbox"/> None <input type="checkbox"/> Light (0-6 mph) <input type="checkbox"/> Moderate (7-14 mph) <input type="checkbox"/> Strong (15-25 mph) <input type="checkbox"/> Storm (Over 25 mph)	
VISIBILITY <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Poor						
NAME OF OPERATOR			OPERATOR ADDRESS			
OPERATOR TELEPHONE NO. ()		DATE OF BIRTH (Mo., Day, Yr.)		OPERATOR'S EXPERIENCE <input type="checkbox"/> None <input type="checkbox"/> Under 100 Hours <input type="checkbox"/> Over 100 Hours		
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		INSURANCE COMPANY		INSTRUCTION IN BOATING SAFETY <input type="checkbox"/> State Course <input type="checkbox"/> U.S. Power Squadron <input type="checkbox"/> USCG Auxiliary <input type="checkbox"/> American Red Cross <input type="checkbox"/> None		
NAME OF OWNER			OWNER ADDRESS			
OWNER TELEPHONE NO. ()		NO. OF PEOPLE ON BOARD		NO. OF PEOPLE BEING TOWED	RENTED BOAT <input type="checkbox"/> Yes <input type="checkbox"/> No	
BOAT NO. 1 (This Vessel)						
BOAT REGISTRATION OR DOCUMENTATION NO.			STATE	HULL IDENTIFICATION NO.	BOAT NAME	
BOAT MANUFACTURER			LENGTH	MODEL	YEAR BUILT	
TYPE OF BOAT <input type="checkbox"/> Open Motorboat <input type="checkbox"/> Cabin Motorboat <input type="checkbox"/> Auxiliary Sail <input type="checkbox"/> Sail (Only) <input type="checkbox"/> Rowboat <input type="checkbox"/> Canoe/Kayak <input type="checkbox"/> Personal Watercraft <input type="checkbox"/> Pontoon Boat <input type="checkbox"/> Houseboat <input type="checkbox"/> Other (Specify)		HULL MATERIAL <input type="checkbox"/> Wood <input type="checkbox"/> Aluminum <input type="checkbox"/> Steel <input type="checkbox"/> Fiberglass <input type="checkbox"/> Rubber/Vinyl/Canvas <input type="checkbox"/> Rigid Hull Inflatable <input type="checkbox"/> Other (Specify)		ENGINE <input type="checkbox"/> Outboard <input type="checkbox"/> Inboard <input type="checkbox"/> Inboard-Sterndrive (VO) <input type="checkbox"/> Airboat	PROPULSION <input type="checkbox"/> Propeller <input type="checkbox"/> Water Jet <input type="checkbox"/> Air Thrust <input type="checkbox"/> Manual <input type="checkbox"/> Sail	PERSONAL FLOTATION DEVICES (PFDs): Was boat adequately equipped with Coast Guard-approved PFDs? (Life jackets) <input type="checkbox"/> Yes <input type="checkbox"/> No Were PFDs accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
		FUEL <input type="checkbox"/> Gasoline <input type="checkbox"/> Diesel <input type="checkbox"/> Electric		NO. OF ENGINES	FIRE EXTINGUISHERS On board? <input type="checkbox"/> Yes <input type="checkbox"/> No Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				TOTAL HORSEPOWER		
OPERATION AT TIME OF ACCIDENT (Check all applicable) <input type="checkbox"/> Cruising <input type="checkbox"/> Changing Direction <input type="checkbox"/> Changing Speed <input type="checkbox"/> Drifting <input type="checkbox"/> Towing <input type="checkbox"/> Being Towed <input type="checkbox"/> Rowing/Paddling <input type="checkbox"/> Sailing <input type="checkbox"/> Launching <input type="checkbox"/> Docking/Undocking <input type="checkbox"/> At Anchor <input type="checkbox"/> Tied to Dock/Moored <input type="checkbox"/> Other (Specify)		ACTIVITY AT TIME OF ACCIDENT (Check any if applicable) <input type="checkbox"/> Fishing <input type="checkbox"/> Fishing Tournament <input type="checkbox"/> Hunting <input type="checkbox"/> Swimming/Diving <input type="checkbox"/> Making Repairs <input type="checkbox"/> Waterskiing/Tubing/Etc. <input type="checkbox"/> Racing <input type="checkbox"/> Whitewater Sports <input type="checkbox"/> Fueling <input type="checkbox"/> Starting Engine <input type="checkbox"/> Non-Recreational <input type="checkbox"/> Other (Specify)		TYPE OF ACCIDENT <input type="checkbox"/> Grounding <input type="checkbox"/> Capsizing <input type="checkbox"/> Flooding/Swamping <input type="checkbox"/> Sinking <input type="checkbox"/> Fire or Explosion (Fuel) <input type="checkbox"/> Fire or Explosion (Other) <input type="checkbox"/> Skier Mishap <input type="checkbox"/> Collision With Vessel <input type="checkbox"/> Collision With Fixed Object <input type="checkbox"/> Collision With Floating Object <input type="checkbox"/> Falls Overboard <input type="checkbox"/> Falls in Boat <input type="checkbox"/> Struck by Boat <input type="checkbox"/> Struck by Motor/Propeller <input type="checkbox"/> Struck Submerged Object <input type="checkbox"/> Hit and Run <input type="checkbox"/> Other (Specify)		WHAT CONTRIBUTED TO ACCIDENT? (Check all applicable) <input type="checkbox"/> Weather <input type="checkbox"/> Excessive Speed <input type="checkbox"/> Improper Lookout <input type="checkbox"/> Restricted Vision <input type="checkbox"/> Overloading <input type="checkbox"/> Improper Loading <input type="checkbox"/> Hazardous Waters <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use <input type="checkbox"/> Hull Failure <input type="checkbox"/> Machinery Failure <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Operator Inexperience <input type="checkbox"/> Operator Inattention <input type="checkbox"/> Congested Waters <input type="checkbox"/> Passenger/Skier Behavior <input type="checkbox"/> Other (Specify)
ESTIMATED SPEED <input type="checkbox"/> Drifting <input type="checkbox"/> Under 10 mph <input type="checkbox"/> 10-20 mph <input type="checkbox"/> Over 20 mph <input type="checkbox"/> Over 40 mph						



DECEASED (If More Than 2 Fatalities, Attach Additional Forms)

NAME OF VICTIM		ADDRESS OF VICTIM		WAS PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DEATH CAUSED BY <input type="checkbox"/> Drowning <input type="checkbox"/> Other (Specify).....		<input type="checkbox"/> Disappearance
NAME OF VICTIM		ADDRESS OF VICTIM		WAS PFD WORN? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DEATH CAUSED BY <input type="checkbox"/> Drowning <input type="checkbox"/> Other (Specify).....		<input type="checkbox"/> Disappearance

INJURED (If More Than 2 Injuries, Attach Additional Forms)

NAME OF VICTIM		ADDRESS OF VICTIM		
DATE OF BIRTH	MEDICAL TREATMENT BEYOND FIRST AID? <input type="checkbox"/> Yes <input type="checkbox"/> No	DESCRIBE INJURY		
	ADMITTED TO HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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	WAS IT INFLATABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NAME OF VICTIM		ADDRESS OF VICTIM		
DATE OF BIRTH	MEDICAL TREATMENT BEYOND FIRST AID? <input type="checkbox"/> Yes <input type="checkbox"/> No	DESCRIBE INJURY		
	ADMITTED TO HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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	WAS IT INFLATABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	

BOAT NO. 2 (If More Than 2 Vessels, Attach Additional Identifying Information)

NAME OF OPERATOR		OPERATOR ADDRESS		
OPERATOR TELEPHONE NO. ()		BOAT REGISTRATION OR DOCUMENTATION NO.	STATE	
NAME OF OWNER		OWNER ADDRESS		
OWNER TELEPHONE NO. ()				

PROPERTY DAMAGE

ESTIMATED AMOUNT This boat and contents: \$.....	Other boat(s) and contents: \$.....	Other property: \$.....
DESCRIBE PROPERTY DAMAGED		

WITNESSES NOT ON THIS VESSEL

NAME	ADDRESS	TELEPHONE NO. ()
NAME	ADDRESS	TELEPHONE NO. ()

PERSON COMPLETING REPORT

NAME	ADDRESS	TELEPHONE NO. ()
SIGNATURE	QUALIFICATION <input type="checkbox"/> Operator <input type="checkbox"/> Owner <input type="checkbox"/> Other (Specify).....	DATE SUBMITTED

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED (Sequence of events. Include failure of equipment. Include a diagram if needed. 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 PFDs.)

FOR AGENCY USE ONLY

CAUSES BASED ON (Check one) <input type="checkbox"/> This report <input type="checkbox"/> Investigation <input type="checkbox"/> Investigation and this report <input type="checkbox"/> Other (Specify).....		
NAME OF REVIEWING OFFICER	DATE RECEIVED	<input type="checkbox"/> RECREATIONAL <input type="checkbox"/> NON-REPORTABLE <input type="checkbox"/> COMMERCIAL
PRIMARY CAUSE	SECONDARY CAUSE	