

Case Number:

STATE OF NEVADA  
DEPARTMENT OF WILDLIFE  
1100 Valley Road, Reno, Nevada 89512



**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 beyond first aid, or property damage in excess of \$2,000. 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 Department of Wildlife, 1100 Valley Road, Reno, Nevada 89512, and shall include a full description of the collision, accident or other casualty. **Insurers and persons who repair damaged vessels must provide written notice of the requirement for filing boating accidents reports, and shall transmit a copy of each notice to the Department of Wildlife.** (NAC 488.440 and **488.445**) **YELLOW FIELDS REQUIRED.**

**COMPLETE ALL BLOCKS (Indicate Those Not Applicable w by "NA")**

NAME AND ADDRESS OF OPERATOR: <input type="text"/>		OPERATOR'S D.O.B.: <input type="text"/>	OPERATOR'S EXPERIENCE: This type of boat: <input type="checkbox"/> Under 20 Hours <input type="checkbox"/> 20 to 100 Hours <input type="checkbox"/> 100 to 500 Hours <input type="checkbox"/> Over 500 Hours	
OPERATOR TELEPHONE NUMBER: <input type="text"/>		OWNER TELEPHONE NO.: <input type="text"/>	Other boat operating experience: <input type="checkbox"/> Under 20 Hours <input type="checkbox"/> 20 to 100 Hours <input type="checkbox"/> 100 to 500 Hours <input type="checkbox"/> Over 500 Hours	
NAME AND ADDRESS OF OWNER <input type="text"/>		RENTED BOAT: <input type="checkbox"/> Yes <input type="checkbox"/> No	NO. OF PERSONS ON BOARD <input type="text"/>	OPERATOR'S SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male
FORMAL INSTRUCTION IN BOATING SAFETY: <input type="checkbox"/> None <input type="checkbox"/> U.S. Power Squadron <input type="checkbox"/> State <input type="checkbox"/> USCG Auxiliary <input type="checkbox"/> American Red Cross <input type="checkbox"/> Other (Indicate) <input type="text"/>				

**VESSEL NO. 1 (This Vessel)**

BOAT REG. NO.: <input type="text"/>	BOAT NAME: <input type="text"/>	BOAT MFG.: <input type="text"/>	BOAT MODEL: <input type="text"/>	MFG. HULL IDENTIFICATION NO.: <input type="text"/>
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 <input type="checkbox"/> Other (Specify) <input type="text"/>		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"/> Other (Specify) <input type="text"/>	ENGINE: <input type="checkbox"/> Outboard <input type="checkbox"/> Inboard-Gasoline <input type="checkbox"/> Inboard-Diesel <input type="checkbox"/> Inboard-Outdrive <input type="checkbox"/> Jet <input type="checkbox"/> Other (Specify) <input type="text"/>	BOAT INFO.: Length of Boat <input type="text"/> Year Boat Built <input type="text"/>
TYPE OF PROPULSION: <input type="checkbox"/> Prop <input type="checkbox"/> Jet <input type="checkbox"/> Sail <input type="checkbox"/> Manual <input type="checkbox"/> Other		No. of Engines <input type="text"/>		Horsepower (Total) <input type="text"/>
Type of Fuel <input type="text"/>		Has Boat had a Vessel Safety Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No		INSURANCE COMPANY: <input type="text"/>
USCG Auxiliary <input type="checkbox"/>		State or Local <input type="checkbox"/>		For Current Year <input type="checkbox"/> Yes <input type="checkbox"/> No

**ACCIDENT DATA**

DATE OF ACCIDENT: <input type="text"/>	TIME: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	BODY OF WATER: <input type="text"/>	BODY OF WATER: <input type="text"/>	LOCATION (Give location precisely): <input type="text"/>	Latitude <input type="text"/>	Longitude <input type="text"/>
STATE: <input type="text"/>	NEAREST CITY OR TOWN: <input type="text"/>		COUNTY: <input type="text"/>			

WEATHER: <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 (Waives Less Than 6") <input type="checkbox"/> Choppy (Waives 6"-2') <input type="checkbox"/> Rough (Waives Over 2'-6") <input type="checkbox"/> Very Rough (Waives Greater Than 6")	TEMPERATURE: (Estimate) Air <input type="text"/> Water <input type="text"/>	WIND: <input type="checkbox"/> None <input type="checkbox"/> Strong (Over 25 mph) <input type="checkbox"/> Light (0-6 mph) <input type="checkbox"/> Moderate (7-14 mph) <input type="checkbox"/> Strong (15-25 mph)	VISIBILITY: Day <input type="checkbox"/> Night <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
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OPERATION AT TIME OF ACCIDENT: (Check All Applicable) <input type="checkbox"/> Commercial Activity <input type="checkbox"/> Cruising <input type="checkbox"/> Approaching Dock <input type="checkbox"/> Water Skiing <input type="checkbox"/> Racing <input type="checkbox"/> Towing <input type="checkbox"/> Being Towed <input type="checkbox"/> Drifting	TYPE OF ACCIDENT: <input type="checkbox"/> At Anchor <input type="checkbox"/> Tied to Dock <input type="checkbox"/> Fueling <input type="checkbox"/> Fishing <input type="checkbox"/> Hunting <input type="checkbox"/> Swimming <input type="checkbox"/> Scuba/Swim <input type="checkbox"/> Other	<input type="checkbox"/> Grounding <input type="checkbox"/> Capsizing <input type="checkbox"/> Flooding <input type="checkbox"/> Sinking <input type="checkbox"/> Fire or Explosion (Fuel) <input type="checkbox"/> Fire of Explosion (Other Than Fuel) <input type="checkbox"/> Collision With Vessel	<input type="checkbox"/> Collision With Fixed Obj. <input type="checkbox"/> Collision With Floating Obj. <input type="checkbox"/> Fall Overboard <input type="checkbox"/> Fall in Boat <input type="checkbox"/> Hit by Boat or Propeller <input type="checkbox"/> Fallen Skier <input type="checkbox"/> Other (Specify)	WHAT IN YOUR OPINION CAUSED THE ACCIDENT: (Check all Applicable) <input type="checkbox"/> Weather <input type="checkbox"/> Excess Speed <input type="checkbox"/> No Proper Lookout <input type="checkbox"/> Overloading <input type="checkbox"/> Improper Loading <input type="checkbox"/> Restrictive Vision <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use
<input type="checkbox"/> Fault of Hull <input type="checkbox"/> Fault of Machinery <input type="checkbox"/> Fault of Equipment <input type="checkbox"/> Hazardous Waters <input type="checkbox"/> Operator Inexperience <input type="checkbox"/> Operator Inattention <input type="checkbox"/> Other				

**LIFE JACKETS**

WAS THE BOAT ADEQUATELY EQUIPED WITH CG APPROVED LIFE JACKETS? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were life jackets accessible Yes <input type="checkbox"/> No <input type="checkbox"/>	Were life jackets used Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the Vessel Carrying Non-approved Flotation Devices? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were life jackets accessible Yes <input type="checkbox"/> No <input type="checkbox"/>	Were life jackets used Yes <input type="checkbox"/> No <input type="checkbox"/>
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**FIRE EXTINGUISHERS**

WERE THE FIRE EXTINGUISHERS USED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF USED LIST TYPE AND HOW MANY USED. <input type="text"/>

PROPERTY DAMAGE (Estimate) This Boat \$ <input type="text"/> Other Boat \$ <input type="text"/> Other Property \$ <input type="text"/>	DESCRIBE PROPERTY DAMAGE <input type="text"/>	NAME AND ADDRESS OF OWNER OF DAMAGED PROPERTY <input type="text"/>
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**COMPLETE BOTH SIDES (OVER)**

**(If more than three fatalities and/or injuries, attach additional forms)**

DECEASED						
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	DEATH CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	DEATH CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	DEATH CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	

INJURED						
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	INJURY CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	INJURY CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	
NAME.:	ADDRESS:	DATE OF BIRTH	WAS VICTIM:	INJURY CAUSED BY:	WAS LIFE JACKET USED:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non-swimmer	<input type="checkbox"/> Drowning <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No What Type: <input type="text"/>	

ACCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED (Sequence of events. If diagram is needed, attach separately. Continue on additional sheets, if necessary. Include any information regarding the involvement of alcohol and/or drugs in causing or contributing to the accident)

VESSEL NO.2 (If more Than Two Vessels, Attach Additional Form(s))		
NAME OF OPERATOR:	OPERATOR ADDRESS:	BOAT REG. NO.:
<input type="text"/>	<input type="text"/>	<input type="text"/>
OPERATOR PHONE NO.:	OWNER ADDRESS:	BOAT LENGTH:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF OWNER:	MFG. HULL ID NO.:	
<input type="text"/>	<input type="text"/>	

OCCUPANTS/WITNESSES		
NAME:	ADDRESS:	PHONE NO.:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME:	ADDRESS:	PHONE NO.:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME:	ADDRESS:	PHONE NO.:
<input type="text"/>	<input type="text"/>	<input type="text"/>

PERSON COMPLETING REPORT		
NAME:	OWNER ADDRESS:	DATE SUBMITTED:
<input type="text"/>	<input type="text"/>	<input type="text"/>
QUALIFICATION (Check One):	TELEPHONE NO.:	
<input type="checkbox"/> Operator <input type="checkbox"/> Owner <input type="checkbox"/> Investigator <input type="checkbox"/> Other	<input type="text"/>	

DO NOT USE FOR REPORTING AUTHORITY REVIEW (Use Agency Date Stamp)				
CAUSE BASED ON (Check One): <input type="checkbox"/> This Report <input type="checkbox"/> This Report and Investigation <input type="checkbox"/> Investigation <input type="checkbox"/> Could not be determined	FOR EACH OPERATOR AND EACH PASSENGER: Indicate whether or not test for alcohol was taken – Yes or No Indicate TYPE of test – Blood, Breath or Other Indicate Test Results – Positive or Negative Indicate Blood Alcohol Content			
PRIMARY CAUSE OF ACCIDENT:				
SECONDARY CAUSE OF ACCIDENT:	Operator	Test	Type	Results
	Passenger			BAC%
	Passenger			
	Passenger			
	Passenger			
NAME OF REVIEWING OFFICER:	DATE RECEIVED:			

REVIEWED BY: