

Mishap Report Worksheet

(Short Form)

- * Date of Mishap: _____ * Local Time of Mishap: _____
- * Mission at Time of Mishap: _____ * Involved a Motor Vehicle: Yes | No

* Coxswain Data: Required if incident occurred while underway on a small boat.

Grade: _____ Age: _____ Months Qualified in Vessel: _____ Months at Unit: _____

- * Mishap directly related to unit mission? Yes | No
- * When this mishap occurred, was all required PPE worn properly by those involved? No | Yes | None required

* PPE Description: (Short narrative describing PPE worn by members involved, any PPE not properly worn and why—specifically addressing funding, training, and any complacency issues)

* Did this Mishap involve a: (Select all that apply)

- Capsizing Ejection Person in Water Motor Vehicle
 Grounding Rollover Accidental Firearm Discharge None of the above

* Enter Short Description of Mishap: _____

* Narrative of Mishap (What, Where, How, Why, Environmental Conditions if applicable)

* Causes(s) and Contributing Factor(s) of Mishap

Sports

If not Sports, check as many that apply from below:

	<u>Personnel</u>		<u>Equipment</u>		<u>Environment</u>
Experience	<input type="checkbox"/> Policies/Procedures	<input type="checkbox"/>	Eng/Design	<input type="checkbox"/>	Weather <input type="checkbox"/>
Qualifications	<input type="checkbox"/> Planning/Risk Assessment	<input type="checkbox"/>	Failure	<input type="checkbox"/>	Noise <input type="checkbox"/>
Judgment	<input type="checkbox"/> Management/Supervision	<input type="checkbox"/>	Inadequate Maint.	<input type="checkbox"/>	Visibility/Lighting <input type="checkbox"/>
Fatigue	<input type="checkbox"/> Communication	<input type="checkbox"/>			Temperature <input type="checkbox"/>

Additional Cause Information:

* Corrective Actions Taken/Lessons Learned:

Medical Information:

* Name: _____ * Age: _____ * Gender: M / F * Grade: _____ * Rate: _____

* Status:

On Duty Coast Guard (Act Duty) On Duty CG Reserve On Duty DOD Contractor NAFA
 Off Duty Coast Guard (Act Duty) On Duty Civilian Off Duty DOD Other Auxiliary

Part of Body Injured:

Abdomen	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Finger	<input type="checkbox"/>	Hip/Pelvis	<input type="checkbox"/>	Lungs	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	Ear	<input type="checkbox"/>	Foot	<input type="checkbox"/>	Internal Organs	<input type="checkbox"/>	Neck	<input type="checkbox"/>
Arm	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Hand	<input type="checkbox"/>	Knee	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>
Back	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	Head	<input type="checkbox"/>	Leg	<input type="checkbox"/>	Wrist	<input type="checkbox"/>

Nature of Injury:

Abrasion	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Gunshot Wound	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Absorption	<input type="checkbox"/>	Cut	<input type="checkbox"/>	Ingestion	<input type="checkbox"/>	Puncture	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	Inhalation	<input type="checkbox"/>	Sprain	<input type="checkbox"/>
Bruise	<input type="checkbox"/>	Electrical Shock	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>		
Burn	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	Occupation Illness, Latent Effects	<input type="checkbox"/>		

Type PPE (Personal Protective Equipment Required/Used)

	<u>Req</u>	<u>Used</u>		<u>Req</u>	<u>Used</u>		<u>Req</u>	<u>Used</u>		<u>Req</u>	<u>Used</u>
Ear	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>	PFD	<input type="checkbox"/>	<input type="checkbox"/>	Motorcycle Helmet/Eye	<input type="checkbox"/>	<input type="checkbox"/>
Eye	<input type="checkbox"/>	<input type="checkbox"/>	Hand	<input type="checkbox"/>	<input type="checkbox"/>	Respirator	<input type="checkbox"/>	<input type="checkbox"/>	Motorcycle Clothing (PPE)	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>				Seat Belt	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Other Description: _____								

Days Hospitalized: _____ Lost Work Days (NFFD/SIQ): _____ Days Restricted (FFLD)

(Civilians Only) Worker Comp Filed? Y / N

Property Damage Information:

* Property General

Aircraft	<input type="checkbox"/>	Aton	<input type="checkbox"/>	Boats	<input type="checkbox"/>	Buildings	<input type="checkbox"/>	Cutter	<input type="checkbox"/>
Equipment	<input type="checkbox"/>	Piers	<input type="checkbox"/>	Vehicles	<input type="checkbox"/>	Other	<input type="checkbox"/>		

* Property Specific: _____

Coast Guard Property Damage:

Operational days lost _____

Cost of CG Owned Parts/Materials: \$ _____

Number of CG Man Hours to Repair Damage: \$ _____

Cost of Commercial Repairs: \$ _____

Non-Coast Guard Property Damage Due to CG Operations:

Description: _____

Cost of Repairs: \$ _____

Coast Guard Auxiliary Facilities Equipment:

Description: _____

Cost of Repairs: \$ _____

Motor Vehicle Information:

* Number of Vehicles Involved in Mishap: _____

* Was the Primary Vehicle a: GMV / PMV * If GMV Include the Gov't Tag Number: _____

Were additional GMV's Involved in the Mishap: Yes | No

Vehicle Type: _____ Gov't Tag Number: _____

Vehicle Type: _____ Gov't Tag Number: _____

Driver Information:

* Driver's Age: _____ * Drivers Gender: Male | Female

* Did the Driver Use All Required PPE? Yes | No

* Driver's License Valid? Yes | No

* Driver Training Completed: _____

* Experience Driving Vehicle Involved in Mishap: Years _____ Months _____

* Was the Driver Fatigued? Yes / No

* Hours of Sleep Last 24 Hrs Preceding Mishap: _____

* Hours of Duty Last 24 Hrs Preceding Mishap: _____

* Hours of Driving Before Mishap: _____

* Drivers Actions at Time of Mishap: _____

* Number of Passengers: _____ * Did All Passengers Use All Required PPE? Yes / No

* Crash Location (State): _____

* Crash Site: On Roadway | Off Roadway

Trailing Information:

* Type of Trailer: Boat | Other | Utility

* Weight of Load/Boat Being Towed: _____ lbs

* Tow Vehicle Weight Load Capacity: _____ lbs

* Trailer Weight Load Capacity: _____ lbs

Maneuver at Time of Mishap:

* Highway Driving: Yes | No

* Launch or Recovery: Yes | No

* Close Quarters Maneuvering: Yes | No

Investigator / Reviewers Information:

* Investigator's Name: _____ * Phone: _____

* Information required to submit the mishap report into the e-Mishap system.