Case Number:

STATE OF IOWA
DEPARTMENT OF NATURAL RESOURCES
WALLACE STATE OFFICE BLDG.
DES MOINES, IOWA 50319-0034

BOAT ACCIDENT OPERATOR'S 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. Any accidents involving death or injury must be reported within 5 days. All reports shall be submitted to the **Iowa DNR Law Enforcement Bureau, Wallace State Office Bldg., Des Moines, Ia. 50319-0034**, and shall include a full description of the collision, accident or other casualty. If you have any questions, call the DNR Des Moines Office - (515)-281-8652.

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

NAME AND ADDRESS OF OPERATOR:

AGE OF OPERATOR:

OPERATOR'S EXPERIENCE:

This Type of Boat:
- ☐ Under 20 Hours
- ☐ 20 to 100 Hours
- ☐ 100 to 500 Hours
- ☐ Over 500 Hours

Other Boat Operating Experience:
- ☐ Under 20 Hours
- ☐ 20 to 100 Hours
- ☐ 100 to 500 Hours
- ☐ Over 500 Hours

OWNER TELEPHONE NO.:

OPERATOR TELEPHONE NO:

NAME AND ADDRESS OF OWNER

RENTED BOAT: ☐ Yes ☐ NO

NO. OF PERSONS ON BOARD:

FORMAL INSTRUCTION IN BOATING SAFETY:
- ☐ None
- ☐ USCG Auxiliary
- ☐ U.S. Power Squadron
- ☐ American Red Cross
- ☐ State
- ☐ Other *(Indicaate)*

VESSEL NO. 1 (This Vessel)

BOAT NO.:	BOAT NAME:	BOAT MAKE:	BOAT MODEL:	MFR. HULL IDENTIFICATION NO.:

TYPE OF BOAT:
- ☐ Open Motorboat
- ☐ Personal Watercraft
- ☐ Pontoon
- ☐ Cabin Motorboat
- ☐ Auxiliary Sail
- ☐ Sail *(Only)*
- ☐ Rowboat
- ☐ Canoe
- ☐ Other *(Specify)*

HULL MATERIAL:
- ☐ Wood
- ☐ Aluminum
- ☐ Steel
- ☐ Fiberglass
- ☐ Rubber/Vinyl/ Canvas
- ☐ Other *(Specify)*

ENGINE:
- ☐ Outboard
- ☐ Inboard-Gasoline
- ☐ Inboard-Diesel
- ☐ Inboard-Outdrive
- ☐ Jet
- ☐ Other *(Specify)*

BOAT DATA *Propulsion)*:
No. of Engines ______
HorsePower *(Total)* ______
Type of Fuel ______

BOAT DATA *(Construction)*:
Length ______
Year Built *(Boat)* ______

Has Boat Had Safety Examination? ☐ Yes ☐ No
USCG Auxiliary ☐
State of Local ☐
For Current Year ☐ Yes ☐ No

INSURANCE COMPANY:

ACCIDENT DATA

DATE OF ACCIDENT:

TIME: ___ am ___ pm

NAME OF BODY OF WATER:

LOCATION *Give Location Precisely)*:

Latitude ______
Longitude ______

STATE:

NEAREST CITY OR TOWN:

COUNTY:

WEATHER:
- ☐ Clear
- ☐ Cloudy
- ☐ Fog
- ☐ Rain
- ☐ Snow
- ☐ Hazy

WATER CONDITIONS:
- ☐ Calm *(Waves Less Than 6")*:
- ☐ Choppy *(Waves 6" - 2')*
- ☐ Rough *(Waves Over 2' - 6')*
- ☐ Very Rough *(Waves Greater Than 6')*
- ☐ Strong Current

TEMPERATURE *(Estimate)*:
Air ______ ° F
Water ______ ° F

WIND:
- ☐ None
- ☐ Light *(0 - 60 mph)*
- ☐ Moderate *(7 - 14 mph)*
- ☐ Strong *(15 - 25 mph)*
- ☐ Storm *(Over 25 mph)*

VISIBILITY:

	Day	Night
Good ...	☐	☐
Fair	☐	☐
Poor	☐	☐

OPERATION AT TIME OF ACCIDENT *(Check All Applicable)*:
- ☐ Commercial Activity
- ☐ Cruising
- ☐ Manueuvering
- ☐ Approaching Dock
- ☐ Leaving Dock
- ☐ Water Skining
- ☐ Racing
- ☐ Towing
- ☐ Being Towed
- ☐ Drifting
- ☐ At Anchor
- ☐ Tied to Dock
- ☐ Fueling
- ☐ Fishing
- ☐ Hunting
- ☐ Skin Diving/Swimming
- ☐ Other *(Specify)*

TYPE OF ACCIDENT:
- ☐ Grounding
- ☐ Capsizing
- ☐ Flooding
- ☐ Sinking
- ☐ Fire or Explosion *(Fuel)*
- ☐ Fire or Explosion *(Other Than Fuel)*
- ☐ Collision With Vessel
- ☐ Collision With Fixed Object
- ☐ Collision With Floating Object
- ☐ Falls Overboard
- ☐ Falls in Boat
- ☐ Hit by Boat or Propeller
- ☐ Fallen Skier/Tubing
- ☐ Other *(Specify)*

WHAT IN YOUR OPINION, CAUSED THE ACCIDENT *(Check All Applicable)*:
- ☐ Weather
- ☐ Excessive Speed
- ☐ No Proper Lookout
- ☐ Overloading
- ☐ Improper Loading
- ☐ Restrictive Vision
- ☐ Alcohol Use
- ☐ Drug Use
- ☐ Fault of Hull
- ☐ Fault of Machinery
- ☐ Fault of Equipment
- ☐ Hazardous Waters
- ☐ Operator Inexperience
- ☐ Operator Inattention
- ☐ Other *(Specify)*

PERSONAL FLOTATION DEVICES (PFD'S)

Was the Boat Adequately Equipped With CG-Approved Flotation Devices? ☐ Yes ☐ No
Were They Accessible? ☐ Yes ☐ No
Were They Used by Survivors? ☐ Yes ☐ No
What Type? ☐ I ☐ II ☐ III ☐ IV ☐ V
Were PFD's Properly Used? ☐ Yes ☐ No

Was the Vessel Carrying Nonapproved Flotation Devices? ☐ Yes ☐ No
Were They Accessible? ☐ Yes ☐ No
Were They Used? ☐ Yes ☐ No

If Yes, Indicate King ______

FIRE EXTINGUSHERS

Were They Used? *(If Yes, List Type(s) and Number Used.)* ☐ Yes ☐ No

______
______
______

PROPERTY DAMAGE *(Estimate)*:
This Boat .... $ ______
Other Boat .... $ ______
Other Property ... $ ______

DESCRIBE PROPERTY DAMAGE:

NAME AND ADDRES OF OWNER OF DAMAGED PROPERTY:

(If More Than Three Fatalities and/or Injuries, Attach Additional Form(s))

DECEASED

NAME	ADDRESS:	DATE OF BIRTH:	WAS VICTIM	DEATH CAUSED BY:	WAS PFD USED:
NAME	ADDRESS:	DATE OF BIRTH:	WAS VICTIM ☐ Swimmer ☐ Nonswimmer	DEATH CAUSED BY: ☐ Drowning ☐ Other	WAS PFD USED: ☐ Yes ☐ No What Type:
NAME	ADDRESS:	DATE OF BIRTH:	WAS VICTIM ☐ Swimmer ☐ Nonswimmer	DEATH CAUSED BY: ☐ Drowning ☐ Other	WAS PFD USED: ☐ Yes ☐ No What Type:
NAME	ADDRESS:	DATE OF BIRTH:	WAS VICTIM ☐ Swimmer ☐ Nonswimmer	DEATH CAUSED BY: ☐ Drowning ☐ Other	WAS PFD USED: ☐ Yes ☐ No What Type:

INJURED

NAME:	ADDRESS:	DATE OF BIRTH:	NATURE OF INJURY:	MEDICAL TREATMENT:
NAME:	ADDRESS:	DATE OF BIRTH:	NATURE OF INJURY:	MEDICAL TREATMENT: ☐ Yes ☐ No
NAME:	ADDRESS:	DATE OF BIRTH:	NATURE OF INJURY:	MEDICAL TREATMENT: ☐ Yes ☐ No
NAME:	ADDRESS:	DATE OF BIRTH:	NATURE OF INJURY:	MEDICAL TREATMENT: ☐ Yes ☐ No

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED ON A SEPARATE SHEET OF PAPER IF NECESSARY AND ATTACH TO THIS REPORT. *(Sequence of events. Include, failure of equipment. If diagram is needed attach separately. 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:	ADDRESS:	BOAT NO.:
TELEPHONE NO.:		BOAT NAME:
NAME OF OWNER:	ADDRESS:	

OCCUPANTS/WITNESSES

NAME:	ADDRESS:	TELEPHONE.:
NAME:	ADDRESS:	TELEPHONE.:
NAME:	ADDRESS:	TELEPHONE.:

PERSON COMPLETING REPORT

SIGNATURE:	ADDRESS:	DATE SUBMITTED:
QUALIFICATION *(Check One)*: ☐ Operator ☐ Owner ☐ Investigator ☐ Other		TELEPHONE NO.:

DO NOT USE — FOR REPORTING AUTHORITY REVIEW (Use Agency Date Stamp)

CAUSED BASED ON *(Check One)*

☐ This Report ☐ Investigation ☐ Investigation and This Report ☐ Could Not Be Determined

PRIMARY CAUSE OF ACCIDENT

NAME OF REVIEWING OFFICER:

DATE RECEIVED:

REVIEW BY:

CPM-47537