

SECTION A - ACCIDENT INFORMATION

1. CHECK ONE <input type="checkbox"/> a. ORIGINAL <input type="checkbox"/> b. CHANGE			2. UIC (Unit Identification Code) (6-Digit Code of Unit Having Accident)		3a. UNIT NAME AND MILITARY ADDRESS (Accountable Unit)			3b. BRANCH (Armor, Infantry, etc.)							
4. DATE OF ACCIDENT			5. TIME OF ACCIDENT (Local Military Time)		6. PERIOD OF DAY (Check one)		7. ACCIDENT OCCURRED (Check one)		8. IF ON POST, NAME OF INSTALLATION/FACILITY		9. ACCIDENT OCCURRED DURING (Check one)				
a. YEAR	b. MONTH	c. DAY			<input type="checkbox"/> a. Dawn	<input type="checkbox"/> b. Day	<input type="checkbox"/> a. On Post			<input type="checkbox"/> a. Combat					
				<input type="checkbox"/> c. Dusk	<input type="checkbox"/> d. Night	<input type="checkbox"/> b. Off Post			<input type="checkbox"/> b. Non-Combat						
10. WERE EXPLOSIVES OR AMMUNITION INVOLVED (Causal or Contributing Role)				11a. EXACT LOCATION OF ACCIDENT (Detailed enough to locate site)											
<input type="checkbox"/> Yes (See DA PAM 385-40) <input type="checkbox"/> No								11b. TYPE OF LOCATION				11c. GRID COORDINATES OR LAT/LONG			

SECTION B - PERSONNEL INFORMATION

12. NAME (Last, First, MI)				27. CLASSIFICATION AT TIME OF ACCIDENT (Check)				28. CAUSE OF INJURY/OCCUPATIONAL ILLNESS (Number in order of severity) (No more than 3)							
13. SOCIAL SECURITY NUMBER (SSN)				14. DOB (YYYYMMDD)				<input type="checkbox"/> a. Active Army	a. Struck Against		g. Bodily Reaction				
15. GENDER (Check) <input type="checkbox"/> a. Male <input type="checkbox"/> b. Female				16. RANK OR GRADE		17. MOS OR JOB SERIES		<input type="checkbox"/> b. Army Civilian	b. Struck By		h. Overexertion				
18a. ADDRESS (Use Official Address for All Military or Government Personnel) (If different than Block 3, add UIC.)								<input type="checkbox"/> c. Army Contractor	c. Fell from Elevation		i. Exposure				
18b. For injured Army Civilians or Contractors, enter home address								<input type="checkbox"/> d. Army Direct Contractor	d. Fell from Same Level		j. External Contact				
19a. DUTY STATUS AT TIME OF ACCIDENT (Check one)		19b. IF OFF DUTY (if on leave/pass)						<input type="checkbox"/> e. Nonappropriated Fund (NAF)	e. Caught In/ Under/ Between		k. Ingested				
<input type="checkbox"/> On Duty		<input type="checkbox"/> Leave		Date From: _____				<input type="checkbox"/> f. Other U.S. Military	f. Rubbed/Abraded		l. Inhaled				
<input type="checkbox"/> Off Duty		<input type="checkbox"/> Pass		Date To: _____				29. BODY PART(S) AFFECTED (Number in order of severity) (No more than 3)							
													<input type="checkbox"/> g. ROTC	a. Body (General)	
20. FLIGHT STATUS (Check one) <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No								<input type="checkbox"/> h. Dependent	b. Head		n. Wrist				
21a. TIME BEGAN WORK: _____								<input type="checkbox"/> i. NGB Tech	c. Forehead		o. Hand				
21b. CONTINUOUS WORK w/o SLEEP: _____								<input type="checkbox"/> j. NGB IDT	d. Eyes		p. Fingers				
22. HRS. SLEEP IN LAST 24: _____								<input type="checkbox"/> k. NGB AT	e. Nose		q. Leg				
23. DAYS LOST/RESTRICTED (not counting day of injury)		24. TREATED IN EMERGENCY ROOM						<input type="checkbox"/> l. NGB ADSW	f. Jaw		r. Knee				
a. Hospitalized: _____ Days		<input type="checkbox"/> a. Yes						<input type="checkbox"/> m. NGB AGR	g. Neck		s. Ankle				
b. Not Hospitalized: _____ Days		<input type="checkbox"/> b. No						<input type="checkbox"/> n. NGB ADT	h. Trunk		t. Foot				
c. Restricted Activity: _____ Days								<input type="checkbox"/> o. NG Activated	i. Chest		u. Toes				
25a. OSHA 300 Log Case Number: _____								<input type="checkbox"/> p. USAR IDT	j. Heart		v. Other (Specify)				
25b. Name of Physician/Health Care Provider: _____								<input type="checkbox"/> q. USAR AT	k. Back						
25c. If treatment was given away from worksite, where was it given?								<input type="checkbox"/> r. USAR ADT	l. Shoulder						
Facility: _____								<input type="checkbox"/> s. USAR FTM	30. TYPE OF INJURY/ILLNESS (Number to Correspond with Block 29)						
Street: _____								<input type="checkbox"/> t. USAR AGR							
City: _____ State: _____								<input type="checkbox"/> u. USAR Activated	a. Burns (Chemical)		m. Puncture Wound				
26. SEVERITY OF ILLNESS/INJURY (Check most severe)				<input type="checkbox"/> a. Fatal (Date of Death _____)				<input type="checkbox"/> v. Foreign Nat. Direct Hire				b. Burns (Thermal)		n. Hernia, Rupture	
				<input type="checkbox"/> b. Permanent Total Disability. Person can never again do gainful work.				<input type="checkbox"/> w. Foreign Nat. Indirect Hire				c. Amputation		o. Frostbite	
				<input type="checkbox"/> c. Permanent Partial Disability. Person loses or can never again use a body part				<input type="checkbox"/> x. Foreign Nat. KATUSA				d. Decompression Sickness		p. Heat Stroke	
				<input type="checkbox"/> d. Days Away from Work. Person misses one or more workdays; bed rest/on quarters.				<input type="checkbox"/> y. Foreign Mil. Attached to the U.S. Army				e. Asphyxiation (Suffocation)		q. Heat Exhaustion	
				<input type="checkbox"/> e. Restricted Work Activity. Person is temporarily unable to perform regular duties; job transfer/light duty/profile.				<input type="checkbox"/> z. Public				f. Fractures		r. Noise Injury/Illness	
				<input type="checkbox"/> f. Medical Treatment Beyond First Aid. Loss of consciousness, needle stick, etc.				<input type="checkbox"/> aa. Not reported				g. Dislocation		s. Needle Stick or Sharp	
				<input type="checkbox"/> g. First Aid Only. Person has one-time treatment of minor injury. (No lost work days.)								h. Abrasions		t. Loss of Consciousness	
				<input type="checkbox"/> h. No Injury.								i. Concussion		u. Other (Specify)	
								j. Sprain/Strain							
								k. Cuts/Lacerations							
								l. Contusion							

SECTION B - PERSONNEL INFORMATION (Continued)

31. Person's action(s) at time of accident (Check one and explain in Block 32.)

<input type="checkbox"/> a. Soldiering	<input type="checkbox"/> i. Patient Care (People/Animals)	<input type="checkbox"/> q. Handling Animal	<input type="checkbox"/> y. Counseling/Advisory
<input type="checkbox"/> b. Combat Soldiering	<input type="checkbox"/> j. Test/Study/Experiments	<input type="checkbox"/> r. Maintenance/Repair/Serviceing	<input type="checkbox"/> z. Sports
<input type="checkbox"/> c. Physical Training	<input type="checkbox"/> k. Educational	<input type="checkbox"/> s. Fabricating	<input type="checkbox"/> aa. Hobbies
<input type="checkbox"/> d. Weapons Firing/Handling	<input type="checkbox"/> l. Information and Arts	<input type="checkbox"/> t. Handling Material/Passengers	<input type="checkbox"/> bb. Passenger
<input type="checkbox"/> e. Engineering or Construction	<input type="checkbox"/> m. Food and Drug Inspection	<input type="checkbox"/> u. Janitorial/Housekeeping/ Grounds Keeping	<input type="checkbox"/> cc. Human movement
<input type="checkbox"/> f. Communications	<input type="checkbox"/> n. Laundry/Dry Cleaning Services	<input type="checkbox"/> v. Food/Drink Preparations	<input type="checkbox"/> dd. Horseplay
<input type="checkbox"/> g. Security/Law Enforcement	<input type="checkbox"/> o. Pest/Plant Control	<input type="checkbox"/> w. Supervisory	<input type="checkbox"/> ee. Bystanding/spectating
<input type="checkbox"/> h. Fire Fighting	<input type="checkbox"/> p. Operating Vehicle or Vessel	<input type="checkbox"/> x. Office	<input type="checkbox"/> ff. Personal Hygiene/Food/Drink Consumption/Sleeping
<input type="checkbox"/> gg. Parachuting (See Instructions DA Pamphlet 385-40)			

(1) Jumper Height	(7) Wind Direction/Speed At Jump Height Drop Zone	(15) Date graduated basic airborne training (YYYYMMDD)
(2) Jumper Weight		
(3) Type of Jump	(8) Jump Altitude	(16) Type of Aircraft
(4) Parachute Type/Model	(9) Position in Stick	
(5) Equipment	(10) Door Exited	(17) Accident factors (parachute): (Explain as necessary)
	(11) Time pre-jump conducted	
	(12) Date of Last Jump	
	(13) Type of Last Jump	
(6) Wt. of Equipment	(14) Number of previous jumps	

32. SPECIFIC DESCRIPTION OF ACTIVITY/TASK

33. ON FIELD EXERCISE/NAMED OPERATION	34. ACTIVITY PART OF TACTICAL TRAINING?	38. REQUIRED PROTECTIVE EQUIPMENT		AVAILABLE?		USED?		N/A
		<input type="checkbox"/> a. Yes (If YES, specify name of exercise/operation.)	<input type="checkbox"/> a. Yes	CHECK APPROPRIATE BLOCK(S)		YES	NO	
<input type="checkbox"/> b. No	<input type="checkbox"/> b. No	<input type="checkbox"/> a. Seat belt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Type of training facility being used (Check one)				<input type="checkbox"/> b. Restraint System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> a. Garrison	<input type="checkbox"/> d. NTC	<input type="checkbox"/> g. Std. range facility/live fire	<input type="checkbox"/> c. Goggles/Glasses/Visor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> b. Local training area	<input type="checkbox"/> e. JRTC	<input type="checkbox"/> h. Other (Specify):	<input type="checkbox"/> d. Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> c. Major training area	<input type="checkbox"/> f. CMTC		<input type="checkbox"/> e. Ear plugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. Type of training participating in at the time of accident (Check/specify)				<input type="checkbox"/> f. IBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> a. School (Specify):				<input type="checkbox"/> g. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> b. UNIT → <input type="checkbox"/> (1) Platoon <input type="checkbox"/> (2) Crew <input type="checkbox"/> (3) Individual				<input type="checkbox"/> h. Helmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> c. On-the-job training				DOT Approved (If Motorcycle)? Yes <input type="checkbox"/> No <input type="checkbox"/>					

37. Last time individual received training prior to accident on activity specified in Block 31? (Check one)				39a. INDIVIDUAL LICENSED TO OPERATE VEHICLE/EQUIPMENT?	39b. MANDATORY 4 hr TRAFFIC SAFETY TRAINING	39c. MSF CERTIFIED
<input type="checkbox"/> a. 0 - 3 months	<input type="checkbox"/> e. 1 - 2 years	<input type="checkbox"/> a. Yes	<input type="checkbox"/> a. Yes	<input type="checkbox"/> a. Yes		
<input type="checkbox"/> b. 3 - 6 months	<input type="checkbox"/> f. More than 2 years	<input type="checkbox"/> b. No	<input type="checkbox"/> b. No	<input type="checkbox"/> b. No		
<input type="checkbox"/> c. 6 - 9 months	<input type="checkbox"/> g. Never	<input type="checkbox"/> c. N/A	If Yes, Date _____	If Yes, Date _____		
<input type="checkbox"/> d. 9 - 12 months	<input type="checkbox"/> h. Not applicable					

40. DID ALCOHOL USE BY THIS INDIVIDUAL CAUSE/CONTRIBUTE TO THIS ACCIDENT? (Check one)		
<input type="checkbox"/> a. Yes BAC %: _____	<input type="checkbox"/> b. No	<input type="checkbox"/> c. Unknown

SECTION B - PERSONNEL INFORMATION (Continued)

41. If drug use by this individual caused/contributed to this accident, check appropriate block.

- a. Prescription
 b. Illegal
 c. Over-the-counter
 d. Supplements
 e. None

42. Were vision enhancement devices being used? (Check appropriate block.)

- a. Yes (Specify type/model in c and d.)
 b. No
 c. TYPE: _____
 d. MODEL: _____

43. Standard/Reference covering activity/task

- | | |
|---|--|
| <input type="checkbox"/> a. Soldier's Manual (Task No.) _____ | <input type="checkbox"/> e. Federal/State Law |
| <input type="checkbox"/> b. CTT (Task No.) _____ | <input type="checkbox"/> f. Other (Specify): _____ |
| <input type="checkbox"/> c. AR/TM/FM (Specify) _____ | <input type="checkbox"/> g. None (Go to Block 45.) |
| <input type="checkbox"/> d. SOP | |

- | | |
|---|---|
| 44. WAS ACTIVITY/TASK PERFORMED IAW STANDARD/REFERENCE? (Check one)
<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No (If NO, complete blocks 45-47.) | 45. DID INDIVIDUAL MAKE A MISTAKE? (Check one)
<input type="checkbox"/> a. Yes (If YES, complete blocks 46-47.) <input type="checkbox"/> b. No |
|---|---|

46. What was the mistake? How was the activity/task performed incorrectly? (Explain below.)

47. Why was mistake made/activity performed incorrectly? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> a. Inadequate school training (content/amount) | <input type="checkbox"/> g. Poor/bad attitude/indiscipline | <input type="checkbox"/> m. Inadequate written procedures (AR, TM, SOP) |
| <input type="checkbox"/> b. Inadequate unit training (content/amount) | <input type="checkbox"/> h. Lack of rest/sleep | <input type="checkbox"/> n. Improper supervision |
| <input type="checkbox"/> c. Inadequate on-the-job training | <input type="checkbox"/> i. Effects of alcohol/drugs/illness | <input type="checkbox"/> o. Other (Specify in narrative) |
| <input type="checkbox"/> d. Fear/excitement/anger | <input type="checkbox"/> j. Inadequate facilities | |
| <input type="checkbox"/> e. Overconfident in own/others abilities/complacent | <input type="checkbox"/> k. Inadequate services | |
| <input type="checkbox"/> f. In a hurry | <input type="checkbox"/> l. Improper equipment design | |
| | | |

- | | | |
|---|--|---|
| 48. Time licensed on this vehicle (Check one)
<input type="checkbox"/> a. Less than one year
<input type="checkbox"/> b. One to two years
<input type="checkbox"/> c. Over two years
<input type="checkbox"/> d. Unlicensed | 49. Total AMV driving mileage (Check one)
<input type="checkbox"/> a. Less than 1,000 miles
<input type="checkbox"/> b. 1,000 - 5,000 miles
<input type="checkbox"/> c. 5,000 - 10,000 miles
<input type="checkbox"/> d. Over 10,000 miles | 50a. Total time in unit (Check one)
<input type="checkbox"/> Less than 6 months
<input type="checkbox"/> 6 months - 1 year
<input type="checkbox"/> Over one year

50b. Date Assigned/Hired (YYYYMMDD)
50c. Date of redeployment from combat zone, if applicable (YYYYMMDD) |
| 51. WHICH ITEM FROM SECTION C APPLIES TO THE INDIVIDUAL NAMED IN BLOCK 12? (This is needed in order to relate the person in Block 12 to the equipment/vehicle below.)
<input type="checkbox"/> Item A <input type="checkbox"/> Item B <input type="checkbox"/> Item C <input type="checkbox"/> Other (Specify) _____ | | |

SECTION C - PROPERTY/MATERIEL INVOLVED (Whether Damaged or Not)

	ITEM A	ITEM B	ITEM C
52. Type of item			
53a. Model number			
53b. Serial number			
54. Ownership (DoD, DA, POV, Unit Person)			
55. Dollar cost of damage.			
56. Rollover protection system installed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
57. Was this item being towed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
58. If towed, enter letter for item doing towing.			
59. Types of collision codes (Pick up to three from list below and enter in blocks.) (In sequence)			

- Types of Collisions**
- | | |
|---|---|
| 1- Going forward and collided with moving vehicle
2- Going forward and collided with parked vehicle
3- Collision while backing
4- Collision with pedestrian
5- Collision with object (other than vehicle/pedestrian)
6- Overturned | 7- Ran off the road
8- Jackknifed
9- Going forward and rear-ended moving vehicle
10- Going forward and rear-ended parked vehicle
11- Collision while turning
12- Other (Specify) |
|---|---|

SECTION C - PROPERTY/MATERIEL INVOLVED (Whether Damaged or Not) (Continued)

60. Component/Part that Failed/Malfunctioned (Complete this section if a materiel failure/malfunction caused/contributed to the accident.)

	ITEM A	ITEM B	ITEM C
a. National Stock Number			
b. Part Number			
c. Describe Part			
d. Manufacturer's Identification Code			
e. EIR/QDR Number			

61. How/Why Part Malfunctioned (Select code from "How" list below and enter in first block; select code from "Why" list and enter in second block.)	HOW	WHY	HOW	WHY	HOW	WHY

How Part Failed/Malfunctioned Codes:

- 1 - Overheated/burned/melted
- 2 - Froze (*temperature*)
- 3 - Obstructed/pinched/clogged
- 4 - Vibrated
- 5 - Rubbed/worn/frayed
- 6 - Corroded/rusted/pitted
- 7 - Overpressured/burst
- 8 - Pulled/stretched
- 9 - Twisted/torqued
- 10 - Compressed/hit/punctured
- 11 - Bent/warped
- 12 - Sheared/cut
- 13 - Decayed/decomposed
- 14 - Electric current action
- 15 - Unknown/Other
- Blank - Not Reported

Why Part Failed/Malfunctioned Codes:

- 1 - Improper equipment design
- 2 - Inadequate maintenance
- 3 - Inadequate manufacture of equipment
- 4 - Inadequate written procedures (*AR, TM, SOP*)
- 5 - Improper supervision
- 6 - Unknown
- 7 - Other (*Specify in narrative*)

SECTION D - ENVIRONMENTAL CONDITIONS INVOLVED

62. Environmental Conditions. (Check environmental conditions present and indicate if conditions caused/contributed to the accident.)

PRESENT	CAUSED/ CONTRIBUTED	CONDITION	PRESENT	CAUSED/ CONTRIBUTED	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	a. Clear/dry; visibility unlimited	<input type="checkbox"/>	<input type="checkbox"/>	k. Wind gust/turbulence
<input type="checkbox"/>	<input type="checkbox"/>	b. Bright, glare	<input type="checkbox"/>	<input type="checkbox"/>	l. Vibrate, shimmy, sway, shake
<input type="checkbox"/>	<input type="checkbox"/>	c. Dark, dim	<input type="checkbox"/>	<input type="checkbox"/>	m. Radiation, laser, sunlight
<input type="checkbox"/>	<input type="checkbox"/>	d. Fog, condensation, frost	<input type="checkbox"/>	<input type="checkbox"/>	n. Holes, rocky, rough, rutted, uneven
<input type="checkbox"/>	<input type="checkbox"/>	e. Mist, rain, sleet, hail	<input type="checkbox"/>	<input type="checkbox"/>	o. Inclined/steep
<input type="checkbox"/>	<input type="checkbox"/>	f. Snow, ice	<input type="checkbox"/>	<input type="checkbox"/>	p. Slippery (<i>not due to precipitation</i>)
<input type="checkbox"/>	<input type="checkbox"/>	g. Dust, fumes, gasses, smoke, vapors	<input type="checkbox"/>	<input type="checkbox"/>	q. Air pressure (<i>bends, decompression, altitude, hypoxia</i>)
<input type="checkbox"/>	<input type="checkbox"/>	h. Noise, bang, static	<input type="checkbox"/>	<input type="checkbox"/>	r. Lightning, static electricity, ground
<input type="checkbox"/>	<input type="checkbox"/>	i. Temperature/humidity (<i>cold, heat</i>)	<input type="checkbox"/>	<input type="checkbox"/>	s. Other (<i>Specify</i>)
<input type="checkbox"/>	<input type="checkbox"/>	j. Storm, hurricane, tornado			

SECTION E - ACCIDENT DESCRIPTION/NARRATIVE (From Blocks 10, 46, 47, 61 and 62)

63. The investigation board will report, in narrative form on letter size paper, the facts, conditions, and circumstances as established during the investigation and present this information in accordance with DA PAM 385-40, paragraph 4-4.

64a. PRINTED/TYPED NAME OF PERSON COMPLETING THIS REPORT		64b. RANK	64c. TITLE
64d. SIGNATURE	64e. DATE OF SIGNATURE (YYYYMMDD)	64f. TELEPHONE NO.	
		64g. EMAIL ADDRESS	

SECTION F - CORRECTIVE ACTION AND COMMAND REVIEW

65. The investigation board will formulate the findings and recommendations on letter sized paper in accordance with the examples contained in DA PAM 385-40, paragraph 4-3.

66a. PRINTED/TYPED NAME OF COMMANDER

66b. RANK

66c. SIGNATURE

66d. DATE OF SIGNATURE
(YYYYMMDD)

66e. TELEPHONE NO.

66f. EMAIL ADDRESS

	a. TYPED NAME/EMAIL ADDRESS	b. SIGNATURE	c. TITLE	d. RANK/DATE
67.				
68.				
69.				

SECTION G - SAFETY OFFICE USE ONLY

70. LOCAL REPORT NO.

71. ARMY HEADQUARTERS

72. ACCIDENT TYPE (Check choice)

<input type="checkbox"/> a. Army Motor Vehicle	<input type="checkbox"/> h. Other Army Vehicle	<input type="checkbox"/> o. Personal Injury - Other
<input type="checkbox"/> b. Army Combat Vehicle	<input type="checkbox"/> i. Fire	<input type="checkbox"/> p. Property Damage - Other
<input type="checkbox"/> c. Army Operated Vehicle	<input type="checkbox"/> j. Chemical Agent	<input type="checkbox"/> q. POV - On Official Business
<input type="checkbox"/> d. POV - Not on Official Business	<input type="checkbox"/> k. Explosive	<input type="checkbox"/> r. Space
<input type="checkbox"/> e. Marine Diving	<input type="checkbox"/> l. Missile	<input type="checkbox"/> s. Commercial Carrier/Transportation
<input type="checkbox"/> f. Marine Underway	<input type="checkbox"/> m. Radiation	
<input type="checkbox"/> g. Marine Not Underway	<input type="checkbox"/> n. Nuclear	

73. NAME OF SAFETY POINT OF CONTACT (POC)

74a. PHONE NO. OF SAFETY OFFICER POC
(DSN, Commercial, etc.)

75. DATE REPORT COMPLETED BY SAFETY OFFICER
(YYYYMMDD)

74b. EMAIL ADDRESS

SECTION H - EXPLOSIVES/AMMUNITION

76. EXPLOSIVE/AMMUNITION INFORMATION:	ITEM 1	ITEM 2	ITEM 3	ITEM 4
a. LOT #				
b. QUANTITY				
c. NET EXPLOSIVE WEIGHT (NEW)				
d. DoDIC/DoDAC				

77. SPECIAL INTEREST

78. SUPPLEMENTAL INFORMATION