

TECHNICAL REPORT OF U.S. ARMY GROUND ACCIDENT

FOR USACRG USE ONLY

REQUIREMENTS CONTROL SYMBOL
CSOCS-308

For use of this form, see DA Pamphlet 385-40; the proponent agency is OCSA.

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 a. YEAR b. MONTH c. DAY		5. TIME OF ACCIDENT (Local Military Time)	6. PERIOD OF DAY (Check one) <input type="checkbox"/> a. Dawn <input type="checkbox"/> b. Day <input type="checkbox"/> c. Dusk <input type="checkbox"/> d. Night		7. ACCIDENT OCCURRED (Check one) <input type="checkbox"/> a. On Post <input type="checkbox"/> b. Off Post	8. IF ON POST, NAME OF INSTALLATION/FACILITY	9. ACCIDENT OCCURRED DURING (Check one) <input type="checkbox"/> a. Combat <input type="checkbox"/> b. Non-Combat	
10. WERE EXPLOSIVES OR AMMUNITION INVOLVED (Causal or Contributing Role) <input type="checkbox"/> Yes (See DA PAM 385-40) <input type="checkbox"/> No		11a. EXACT LOCATION OF ACCIDENT (Detailed enough to locate site)				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. Struck Against <input type="checkbox"/> b. Struck By <input type="checkbox"/> c. Fell from Elevation <input type="checkbox"/> d. Fell from Same Level <input type="checkbox"/> e. Caught In/ Under/ Between <input type="checkbox"/> f. Rubbed/Abraded <input type="checkbox"/> g. Bodily Reaction <input type="checkbox"/> h. Overexertion <input type="checkbox"/> i. Exposure <input type="checkbox"/> j. External Contact <input type="checkbox"/> k. Ingested <input type="checkbox"/> l. Inhaled	
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"/> a. Active Army <input type="checkbox"/> b. Army Civilian <input type="checkbox"/> c. Army Contractor <input type="checkbox"/> d. Army Direct Contractor <input type="checkbox"/> e. Nonappropriated Fund (NAF) <input type="checkbox"/> f. Other U.S. Military <input type="checkbox"/> g. ROTC		<input type="checkbox"/> m. Arm <input type="checkbox"/> n. Wrist <input type="checkbox"/> o. Hand <input type="checkbox"/> p. Fingers <input type="checkbox"/> q. Leg <input type="checkbox"/> r. Knee <input type="checkbox"/> s. Ankle <input type="checkbox"/> t. Foot <input type="checkbox"/> u. Toes <input type="checkbox"/> v. Other (Specify)
18a. ADDRESS (Use Official Address for All Military or Government Personnel) (if different than Block 3, add UIC.)		18b. For injured Army Civilians or Contractors, enter home address		29. BODY PART(S) AFFECTED (Number in order of severity) (No more than 3)	
19a. DUTY STATUS AT TIME OF ACCIDENT (Check one) <input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty	19b. IF OFF DUTY (if on leave/pass) <input type="checkbox"/> Leave Date From: _____ <input type="checkbox"/> Pass Date To: _____	<input type="checkbox"/> h. Dependent <input type="checkbox"/> i. NGB Tech <input type="checkbox"/> j. NGB IDT <input type="checkbox"/> k. NGB AT <input type="checkbox"/> l. NGB ADSW <input type="checkbox"/> m. NGB AGR <input type="checkbox"/> n. NGB ADT <input type="checkbox"/> o. NG Activated <input type="checkbox"/> p. USAR IDT <input type="checkbox"/> q. USAR AT <input type="checkbox"/> r. USAR ADT <input type="checkbox"/> s. USAR FTM <input type="checkbox"/> t. USAR AGR <input type="checkbox"/> u. USAR Activated <input type="checkbox"/> v. Foreign Nat. Direct Hire <input type="checkbox"/> w. Foreign Nat. Indirect Hire <input type="checkbox"/> x. Foreign Nat. KATUSA <input type="checkbox"/> y. Foreign Mil. Attached to the U.S. Army <input type="checkbox"/> z. Public <input type="checkbox"/> aa. Not reported		<input type="checkbox"/> a. Body (General) <input type="checkbox"/> b. Head <input type="checkbox"/> c. Forehead <input type="checkbox"/> d. Eyes <input type="checkbox"/> e. Nose <input type="checkbox"/> f. Jaw <input type="checkbox"/> g. Neck <input type="checkbox"/> h. Trunk <input type="checkbox"/> i. Chest <input type="checkbox"/> j. Heart <input type="checkbox"/> k. Back <input type="checkbox"/> l. Shoulder	
20. FLIGHT STATUS (Check one) <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No		21a. TIME BEGAN WORK: _____		<input type="checkbox"/> a. Burns (Chemical) <input type="checkbox"/> b. Burns (Thermal) <input type="checkbox"/> c. Amputation <input type="checkbox"/> d. Decompression Sickness <input type="checkbox"/> e. Asphyxiation (Suffocation) <input type="checkbox"/> f. Fractures <input type="checkbox"/> g. Dislocation <input type="checkbox"/> h. Abrasions <input type="checkbox"/> i. Concussion <input type="checkbox"/> j. Sprain/Strain <input type="checkbox"/> k. Cuts/Lacerations <input type="checkbox"/> l. Contusion	
21b. CONTINUOUS WORK w/o SLEEP: _____		22. HRS. SLEEP IN LAST 24: _____		30. TYPE OF INJURY/ILLNESS (Number to Correspond with Block 29)	
23. DAYS LOST/RESTRICTED (not counting day of injury) a. Hospitalized: _____ Days b. Not Hospitalized: _____ Days c. Restricted Activity: _____ Days	24. TREATED IN EMERGENCY ROOM <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No	25a. OSHA 300 Log Case Number: _____		<input type="checkbox"/> m. Puncture Wound <input type="checkbox"/> n. Hernia, Rupture <input type="checkbox"/> o. Frostbite <input type="checkbox"/> p. Heat Stroke <input type="checkbox"/> q. Heat Exhaustion <input type="checkbox"/> r. Noise Injury/Illness <input type="checkbox"/> s. Needle Stick or Sharp <input type="checkbox"/> t. Loss of Consciousness <input type="checkbox"/> u. Other (Specify)	
25b. Name of Physician/Health Care Provider: _____		25c. If treatment was given away from worksite, where was it given? Facility: _____ Street: _____ City: _____ State: _____		<input type="checkbox"/> a. Fatal (Date of Death _____) <input type="checkbox"/> b. Permanent Total Disability. Person can never again do gainful work. <input type="checkbox"/> c. Permanent Partial Disability. Person loses or can never again use a body part. <input type="checkbox"/> d. Days Away from Work. Person misses one or more workdays; bed rest/on quarters. <input type="checkbox"/> e. Restricted Work Activity. Person is temporarily unable to perform regular duties; job transfer/light duty/profile. <input type="checkbox"/> f. Medical Treatment Beyond First Aid. Loss of consciousness, needle stick, etc. <input type="checkbox"/> g. First Aid Only. Person has one-time treatment of minor injury. (No lost work days.) <input type="checkbox"/> h. No Injury.	

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	(15) Date graduated basic airborne training (YYYYMMDD)
(2) Jumper Weight	Jump Height Drop Zone	
(3) Type of Jump	(8) Jump Altitude	(16) Type of Aircraft
(4) Parachute Type/Model	(9) Position in Stick	
(5) Equipment	(10) Door Exited	
	(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 <input type="checkbox"/> a. Yes (If YES, specify name of exercise/operation.) <input type="checkbox"/> b. No	34. ACTIVITY PART OF TACTICAL TRAINING? <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No	38. REQUIRED PROTECTIVE EQUIPMENT		AVAILABLE?	USED?	N/A	
		CHECK APPROPRIATE BLOCK(S)	YES	NO	YES		NO
35. Type of training facility being used (Check one)		<input type="checkbox"/> a. Seat belt	<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"/> b. Restraint System	<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"/> c. Goggles/Glasses/Visor	<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"/> d. Gloves	<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"/> e. Ear plugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> a. School (Specify):	<input type="checkbox"/> g. Std. range facility/live fire <input type="checkbox"/> h. Other (Specify):	<input type="checkbox"/> f. IBA	<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"/> g. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> c. On-the-job training		<input type="checkbox"/> h. Helmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> d. Other (Specify):		DOT Approved (If Motorcycle)? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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? <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. N/A	39b. MANDATORY 4 hr TRAFFIC SAFETY TRAINING <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No If Yes, Date _____	39c. MSF CERTIFIED <input type="checkbox"/> a. Yes <input type="checkbox"/> b. No If Yes, Date _____			
<input type="checkbox"/> a. 0 - 3 months	<input type="checkbox"/> e. 1 - 2 years	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					
<input type="checkbox"/> b. 3 - 6 months	<input type="checkbox"/> f. More than 2 years						
<input type="checkbox"/> c. 6 - 9 months	<input type="checkbox"/> g. Never						
<input type="checkbox"/> d. 9 - 12 months	<input type="checkbox"/> h. Not applicable						

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

- a. Soldier's Manual (Task No.) e. Federal/State Law
 b. CTT (Task No.) f. Other (Specify):
 c. AR/TM/FM (Specify) g. None (Go to Block 45.)
 d. SOP

44. WAS ACTIVITY/TASK PERFORMED IAW STANDARD/REFERENCE? (Check one)

- a. Yes b. No (If NO, complete blocks 45-47.)

45. DID INDIVIDUAL MAKE A MISTAKE? (Check one)

- a. Yes (If YES, complete blocks 46-47.) 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)

- a. Less than one year
 b. One to two years
 c. Over two years
 d. Unlicensed

49. Total AMV driving mileage (Check one)

- a. Less than 1,000 miles
 b. 1,000 - 5,000 miles
 c. 5,000 - 10,000 miles
 d. Over 10,000 miles

50a. Total time in unit (Check one)

- Less than 6 months
 6 months - 1 year
 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.)

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

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

60. Component/Part that Failed/Malfunctioned (Complete this section if a material 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 (not due to precipitation)
<input type="checkbox"/>	<input type="checkbox"/>	g. Dust, fumes, gasses, smoke, vapors	<input type="checkbox"/>	<input type="checkbox"/>	q. Air pressure (bends, decompression, altitude, hypoxia)
<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 (cold, heat)	<input type="checkbox"/>	<input type="checkbox"/>	s. Other (Specify)
<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)

a. Army Motor Vehicle

h. Other Army Vehicle

o. Personal Injury - Other

b. Army Combat Vehicle

i. Fire

p. Property Damage - Other

c. Army Operated Vehicle

j. Chemical Agent

q. POV - On Official Business

d. POV - Not on Official Business

k. Explosive

r. Space

e. Marine Diving

l. Missile

s. Commercial Carrier/Transportation

f. Marine Underway

m. Radiation

g. Marine Not Underway

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

