

Expert Mode Worksheet – AGAR



Instructions: Use this worksheet to assist you in creating a 285-AB accident report in ReportIt using Expert mode. Because Expert mode does not always follow the form flow, this worksheet can assist you in gathering only the information you need and then enter the accident details in ReportIt.

*required

Investigation board (if applicable)

Instructions: Search for a board member using the AKO user name. All fields are populated from this search except branch and board position. You can update permissions for each member as deemed necessary.

Member Name: *	Member AKO Email Address: *
Member Rank:	Member Branch:
Member Classification:	Member Board Position: *

General Accident Information

Date and time of accident: * YYYYMMDD HHMM	Period of Day * <input type="checkbox"/> Dawn <input type="checkbox"/> Day <input type="checkbox"/> Dusk <input type="checkbox"/> Night	Did accident occur during combat? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Due to Army operations? * Yes <input type="checkbox"/> No <input type="checkbox"/>
Explosives present? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, Were explosives or ammunition involved? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Brief description of the accident (One-liner description for ReportIt use only):			
Accountable unit UIC: *		Accountable unit name: *	
Unit Military address: *	City: *	Country: *	
State (if applicable): *	Zip Code: *	Branch:	Army Headquarters: *
Accident Location: Country: * State (if applicable): *	Occur on post? * Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Installation: *	Describe the exact location of the accident: *	
Type of location: *		Coordinates:	
Briefly describe the mission the individual or unit was conducting at the time of the accident. If off duty, state so. *			
METL Task? * Yes <input type="checkbox"/> No <input type="checkbox"/>			

Brief Synopsis of the accident (block 40): *

Personnel				
Personnel classification: *	Rank/Pay Grade: *	Last: *	First: *	MI:
Social security number: ____-____-____	Date of birth: YYYYMMDD	Gender: * M F Unknown	MOS or Civilian Job Series: *	
Unit Information (Military Only): *	On duty? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Flight Status: (*if on duty) Yes <input type="checkbox"/> No <input type="checkbox"/>	Date hired or assigned to unit: (*if on duty) YYYYMMDD	
Time began work: (* if on-duty) HHMM	Hrs worked without sleep:	Hrs of sleep in last 24 hrs:	Date returned from deployment: (* If Off-Duty and deployed in past year) YYYYMMDD	

Off-Duty			
On Leave or Pass (If Off-Duty): * Leave <input type="checkbox"/> Pass <input type="checkbox"/> PCS <input type="checkbox"/> TDY <input type="checkbox"/> None of the Above <input type="checkbox"/>	Leader Contact Prior to Accident: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes: What was the level of leadership?	If off-duty, Deployed within 365 days prior to accident? * Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Where deployed: # Days deployed:	Notified would deploy soon? Yes <input type="checkbox"/> No <input type="checkbox"/>
If on Leave or Pass: From Date: YYYYMMDD To Date: YYYYMMDD During what phase of Leave/Pass did this accident occur?	What type of contact occurred? <input type="checkbox"/> ASMIS-1 <input type="checkbox"/> Brief <input type="checkbox"/> Counseling <input type="checkbox"/> Trip Planning <input type="checkbox"/> Vehicle Inspection <input type="checkbox"/> Other (Specify)		

Extent of injury: *

Fatal

Permanent total disability

Permanent partial disability

Days away from work (lost days case)

Restricted work activity

Medical treatment beyond first aid

First aid

No Injury

Personnel				
Injured Personnel				
If "Fatal", date of death: YYYYMMDD	Injury: Body part affected? *	Injury to this body part? *	Cause of injury? *	
Days Away From Work: (*if Extent of Injury – Days away from work)	Days Hospitalized:		Days of restricted activity: (*if Extent of Injury – Restricted work activity)	
OSHA Form 300 (log) Case #:	Treated in emergency room: * Yes <input type="checkbox"/> No <input type="checkbox"/>		Name of physician/healthcare provider:	
Treatment away from worksite? * Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" to treatment away from worksite: Name of Facility: Country: Address/City/State/Zip:				
Task or activity being performed at time of accident? *	Description of activity: (Activity type determines the fields that display. Parachute fields are below to assist you in completing the form.) *			
If Parachute activity				
Height of jumper: * Weight of jumper: *	Type of jump: *	Wind direction at jump height: * Speed at jump height: *	Wind direction at drop zone: * Speed at drop zone: *	
Position in stick: *	Door Exited: *	Jump altitude: *	Date graduated from basic airborne training: YYYYMMDD	Time Pre-jump conducted: * HHMM
Number of previous jumps: *	Type of last jump prior to accident: * Date of last jump: * YYYYDDMM	Total weight of equipment: *	Parachute Model: *	Aircraft Model: *
Parachute Equipment: *				

Personnel

Accident factors involved:	Explain accident factors (as necessary):
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Was individual participating in: * <input type="checkbox"/> Conflict/Operational Contingency <input type="checkbox"/> Field Exercise Training (FXT) If Field Exercise, Name of operation/exercise: * _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown	Part of tactical training? * Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Type of Training Facility Being Used: *
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Last time individual received training prior to accident on the activity: <input type="checkbox"/> 0 – 3 Months <input type="checkbox"/> 3 – 6 Months <input type="checkbox"/> 6 – 9 Months <input type="checkbox"/> 9 – 12 Months <input type="checkbox"/> 1 – 2 Years <input type="checkbox"/> More Than 2 Years <input type="checkbox"/> Never <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable	PPE Equipment:	Required?	Available?	Used?

If activity is Operating Vehicle:	Was individual licensed to operate vehicle/equipment: * Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Did individual receive the mandatory 4-hour traffic safety training: * Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date of traffic safety training: (YYYYMMDD)			
	Motorcycle Safety Foundation (MSF) certified? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, date of certification: (YYYYMMDD)			

Did alcohol cause or contribute to the accident? * Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If "Yes", blood alcohol percentage: * _____%	Did drug use cause or contribute to the accident? * Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If "Yes", drug type:	Night vision device used? * Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", what type:
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Personnel Mistake

Made a mistake that cause or contributed to the accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", complete mistake questions.	What mistake? *	How was it performed improperly?
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PersonnelAdd root cause

What was the Root Cause: *

Description of root cause and how it caused the mistake:

Add Corrective Action

Corrective Action (code): *

Level to be implemented: *

If Army, which Army agency is responsible:

What do you recommend:

Materiel			
Type of property/materiel involved in accident (Nomenclature): *		Serial Number:	
Estimated cost of damage? \$ _____	Model number: *	Owner of property:	
Collision Type:		Is this item an explosive or ammunition? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", complete the Explosive/Ammunition questions otherwise skip this section.	
If Explosive/Ammunition			
Net Explosive Weight:	Lot Number:	DoDIC/DoDAC Code:	Quantity: *
Component/Parts failed or malfunctioned? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", complete the component/part failure/malfunction questions otherwise skip this section.			
Component/Part Failure/Malfunction			
Nomenclature: *	Part Number: *	National Stock Number: *	Manufacturer: * EIR/QDR Submitted: * Yes <input type="checkbox"/> No <input type="checkbox"/>
Failure*	Root Cause*	How did this underlying reason cause the failure/malfunction?	
Corrective Action:	Describe the recommendation?	What level is responsible for the implementing the recommendation? If Army, give Army agency:	

Risk Management (if applicable)		
<p>What level was the mission or training conducted?</p>	<p>Was Risk Management performed? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Rank: Duty Position:</p>	<p>Who accepted the risk? Rank: Duty Position</p>
<p>Risk Management Communicated: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, how was the risk management process communicated (check all that apply)? <input type="checkbox"/> Order <input type="checkbox"/> Verbal/Brief <input type="checkbox"/> Worksheet <input type="checkbox"/> Unknown <input type="checkbox"/> Other</p>	<p>Was the accident event identified or considered during the risk management process? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Risk Level: Control Measures Applied: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Risk Level After Controls Applied: Who was responsible for implementing Controls? Rank: Duty Position: Was the accident event accepted as residual risk? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>Who was in charge during the mission/training? Rank: Duty Position:</p>	<p>Who was the Senior Leader present during mission/training? Rank: Duty Position:</p>	

Environmental (If Applicable)		
Environmental condition present at time of accident:	Contribution? *	How confident are you of the effect on the accident? <input type="checkbox"/> Definitely <input type="checkbox"/> Suspected <input type="checkbox"/> Undetermined <input type="checkbox"/> None
	Describe how the environmental condition actually caused and/or contributed to the accident (If Present and Contributing or Present and Contributing to the Severity):	
What corrective action is recommended:	Describe corrective actions:	Unit Level for implementation: If Army, Army Agency:

Witness (if applicable)				
Promise of Confidentiality: * Limited Use <input type="checkbox"/> General Use <input type="checkbox"/>	Witness Name: Last: * _____ First: * _____ MI: _____	Residing Address: * Country: _____ State: _____ Address: _____ City: _____ Zip: _____ - _____	Duty/Work Phone #: _____ Date of birth: _____ YYYYMMDD	Occupation or job title: * Organization or Company: Rank or pay grade: *
Witness background: *			Location at time of accident: *	
Interview (If Applicable)				
Date of interview: * _____ YYYYMMDD	Board member conducting interview: *	Interview summary: *		
Was the witness given a promise of confidentiality that was approved by the Commander, USACRC? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Promise of confidentiality offered? Yes <input type="checkbox"/> No <input type="checkbox"/>	If offered, was it declined? Yes <input type="checkbox"/> No <input type="checkbox"/>		