

# Guided Worksheet - AGAR



**Instructions:** Use this worksheet to assist you in creating a 285-AB accident report in ReportIt using Guided mode. Because Guided 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

General Accident Information			
Date and time of accident: * YYYYMMDD HHMM	Period of Day*	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"/>
Brief description of the accident (One-liner description for ReportIt use only):			
Describe the mission the individual or unit was conducting at the time of the accident. If off duty, state so. *			
Was this a Mission Essential Task List (METL) task? *		Accountable unit UIC: *	Accountable unit name: *
Country unit is located: *	Military address: *	City: *	
State (if applicable): *	Army Headquarters: *	Army Branch:	
Occur on post? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Country: *  State (as required): *	If "Yes" to occur on post, enter name of nearest installation/facility: *	Explosives present? * Yes <input type="checkbox"/> No <input type="checkbox"/>  If "Yes", explosives involved in the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Describe the exact location of the accident: *		Type of location: *	Coordinates:
Brief synopsis of the accident: *			

Personnel (If Applicable)						
Personnel classification: *		Rank/Pay Grade: *		Last: *		First: *
MI	Social security number: ____-____-____	Date of birth: YYYYMMDD	Gender: * M F Unknown	In a flight status: * Yes <input type="checkbox"/> No <input type="checkbox"/>		MOS: *
Assigned UIC: (only if different from above) *		Date hired or assigned to unit: (*if on-duty) YYYYMMDD	On duty? * Yes <input type="checkbox"/> No <input type="checkbox"/>		Time began work: * HHMM	Hrs worked without sleep?
Hrs of sleep in last 24 hrs:	Deployed within 365 days prior to accident? (*if off-duty) Yes <input type="checkbox"/> No <input type="checkbox"/>		Where deployed: # Days deployed:			
Date returned from deployment: YYYYMMDD	Notified would deploy soon? Yes <input type="checkbox"/> No <input type="checkbox"/>		Injured? * Yes <input type="checkbox"/> No <input type="checkbox"/>	Extent of injury: (*if injured) <input type="checkbox"/> Fatal <input type="checkbox"/> Permanent total disability <input type="checkbox"/> Permanent partial disability <input type="checkbox"/> Days away from work (lost days case) <input type="checkbox"/> Restricted work activity <input type="checkbox"/> Medical treatment beyond first aid <input type="checkbox"/> First aid		
If "Fatal", date of death: * YYYYMMDD	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:			Days lost due to hospitalization:		OSHA Form 300 (log) Case #:	
			Days lost not due to hospitalization: (*if Days away from work)			
			Days restricted: (*if Restricted work activity)			
If Injured:						
Body part affected? *		Injury to this body part? *		Cause of injury? *		
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.) *				

Personnel (If Applicable)				
When was the last time this individual received training for this activity prior to the accident? *				
<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"/> NA				
If Parachute activity				
Height of jumper: *	Equipment used: *	Total weight of equipment: *	Parachute Model: *	Aircraft Model: *
Weight of jumper: *				
Altitude at jumper exit: *	Number in stick to exit door: *	Which exit door: *	Type of jump: *	Time of jump: * HHMM
Wind direction at jump height: *	Wind direction at drop zone: *	How many jumps prior to accident: *	Type of last jump prior to accident: *	Date graduated from basic airborne training:
Speed: *	Speed: *		When: * YYYYDDMM	YYYYMMDD
Accident factors involved:	Explain accident factors (as necessary):			
Was individual participating in: *		Part of tactical training? *		
<input type="checkbox"/> Conflict/Operational Contingency <input type="checkbox"/> Field Exercise Training (FXT) Name of operation/exercise: * _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown		Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, What type of training facility was used? *		
Night vision device used? *	Did alcohol cause or contribute to the accident? *	Did drug use cause or contribute to the accident? *		
Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", what type: *	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If "Yes", blood alcohol percentage: * _____%	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If "Yes", drug type:		
If activity is Operating Vehicle:	Was individual licensed to operate vehicle/equipment: *			
	Did individual receive the mandatory 4-hour traffic safety training: *			
	Date of traffic safety training: (YYYYMMDD)			
	Was individual riding a motorcycle at the time of accident: *			
	If Yes, Motorcycle Safety Foundation (MSF) certified?			
	If Yes, date of certification: (YYYYMMDD)			

Personnel protective equipment required, available or used? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", what type of equipment? Required? <input type="checkbox"/> Available? <input type="checkbox"/> Used? <input type="checkbox"/>
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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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<u>Add root cause</u> Why was mistake made:  Description of root cause and how it caused the mistake:	<u>Add Corrective Action</u> What do you recommend: What corrective actions were taken or planned:  Level to be implemented: If Army, which Army agency is responsible:
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**Material**

Type of property/materiel involved in accident:	Model number:
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Serial Number:	Owner of property:	Estimated cost of damage? \$ _____
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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.
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**Explosive/Ammunition**

Reaction (if any) for this explosive device: Multiple <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/>	Lot Number:	Quantity:	Net Explosive Weight:	DoDIC/DoDAC Code:
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Component/Parts failed or malfunctioned?  
 Yes  No   
 If "Yes", complete the component/part failure/malfunction questions otherwise skip this section.

**Component/Part Failure/Malfunction**

Describe part:	Part Number:	National Stock Number:	Manufacturer:	EIR/QDR Submitted: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" EIR/QDR #: _____
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Describe the failure/malfunction of the component/part:	Underlying reason for the failure/malfunction?	How did this underlying reason cause the failure/malfunction?
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What are the recommendations?	Describe the recommendation?	What level is responsible for the implementing the recommendation?  If Army, give Army agency:
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**Risk Management (if applicable)**

What level was the mission or training conducted?	Rank of person who approved mission/training?	Duty position of person who approved the mission/training?	
Rank of person in charge of mission/training:	Duty position of person in charge of mission/training:	Rank of senior leader during the mission/training:	Duty position of senior leader present during mission/training:

Was risk management performed? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes": Rank of person performing risk management:  Duty position of person:
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<p>Was the risk management process communicated?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes": Which methods of communication were used? (You can select more than one)</p> <p><input type="checkbox"/> Order <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Verbal/Brief <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Worksheet</p>
<p>Was the accident event identified or considered during risk management?</p> <p><b>If "No" skip to Environmental Section.</b></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>What was the level of identified risk? (Select one)</p> <p><input type="checkbox"/> Low <input type="checkbox"/> Extremely High</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> High</p>
<p>Were control measures applied?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>If "Yes":</p> <p>What was the rank of the person who was responsible for implementing controls?</p> <p>What was the duty position of the person who was responsible for implementing controls?</p> <p>What was the level of risk after the controls were applied?</p> <p><input type="checkbox"/> Low <input type="checkbox"/> Extremely High</p> <p><input type="checkbox"/> Moderate <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> High</p>
<p>Was the potential for the accident event accepted as residual risk? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

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

Witness (if applicable)				
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: *	
Witness (if applicable)				
	Date of interview: * _____ YYYYMMDD	Board member conducting interview: *	Interview summary: *	
	Promise of confidentiality offered?	Promise of confidentiality offered?	If offered, was it declined?	