

<b>U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT (AGAR)</b> For use of this form, see and DA Pamphlet 385-40; the proponent agency is OCSA												REQUIREMENTS CONTROL SYMBOL CSOCS-308			
1. TIME & DATE OF ACCIDENT		a. Yr	b. Mth	c. Day	d. Time	2. PERIOD OF DAY <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Dusk <input type="checkbox"/> Dawn		3. ACDT CLASS		4. COMBAT STATUS <input type="checkbox"/> Combat <input type="checkbox"/> Non-Combat					
5. UNIT IDENTIFICATION		a. UIC (6-digit Code)			b. Unit Address				c. Unit's Branch		5d. Army HQ's				
6. LOCATION OF ACCIDENT		a. Exact Location						b. Type Location		6c. Grid Coordinates/Lat-Long					
d. State/Country			e. <input type="checkbox"/> Off Post <input type="checkbox"/> On Post Name:						7. EXPLOSIVES/AMMO INVOLVED? <input type="checkbox"/> Yes <input type="checkbox"/> No						
8. MISSION		a. Briefly describe the mission.								b. METL Task? <input type="checkbox"/> Yes <input type="checkbox"/> No					
9. VEHICLE/EQUIPMENT/MATERIEL INVOLVED															
#1	a. Type of Item (Nomenclature)			b. Make/Model #			c. Serial #		d. Ownership		e. Estimated Cost of Damage		f. Vehicle Collision		
	Materiel Failure/Malfunction Information (Blks 9g-9l)														
	g. Failure Mode		h. Part Nomenclature			i. Part #		j. Part NSN		k. Part Manufacturer Code		l. EIR/QDR Submitted			
												<input type="checkbox"/> Yes <input type="checkbox"/> No			
#2	a. Type of Item (Nomenclature)			b. Make/Model #			c. Serial #		d. Ownership		e. Estimated Cost of Damage		f. Vehicle Collision		
	Materiel Failure/Malfunction Information (Blks 9g-9l)														
	g. Failure Mode		h. Part Nomenclature			i. Part #		j. Part NSN		k. Part Manufacturer Code		l. EIR/QDR Submitted			
												<input type="checkbox"/> Yes <input type="checkbox"/> No			
10. WHY DID THE MATERIEL FAIL/MALFUNCTION? (Check the root causes(s) in Blk 10a. In Blk 10b., explain how the root causes(s) led to the materiel failure/malfunction.)										b. Describe how the materiel failed/malfunctioned and explain why (root cause).					
a.	LEADER (Not ready, willing, or able to enforce standards)		STDS/PROCEDURES (Not clear, Not practical)		SUPPORT (Short comings in type, capability, amount or condition of equip/supplies/ services/facilities)										
<input type="checkbox"/>	Direct Supervision		<input type="checkbox"/>	AR	<input type="checkbox"/>	SOP	<input type="checkbox"/>	Equip/Materiel Improperly Designed						<input type="checkbox"/>	Inadequate Manufacture
<input type="checkbox"/>	Unit Command Supervision		<input type="checkbox"/>	TM	<input type="checkbox"/>	Other	<input type="checkbox"/>	Equip/Materiel Not Provided						<input type="checkbox"/>	Inadequate Maintenance
<input type="checkbox"/>	Higher Command Supervision		<input type="checkbox"/>	FM	<input type="checkbox"/>	None Exists	<input type="checkbox"/>	Inadequate Facilities/Services						<input type="checkbox"/>	Other
11a. NAME (Last, First, MI) (include Address and UIC if different than Blks 5a and 5b. )				12. SSN			13a. PERSONNEL CLASSIFICATION			13b. DATE ASSIGNED/HIRED (YYYYMMDD)					
				11b. HOME ADDRESS				13c. DATE OF REDEPLOYMENT FROM COMBAT ZONE, IF APPLICABLE (YYYYMMDD)			14. MOS/JOB SERIES		15a. DUTY STATUS		15b. IF OFF DUTY (if on leave/pass)
<input type="checkbox"/> On-duty <input type="checkbox"/> Off-duty		<input type="checkbox"/> Leave <input type="checkbox"/> Pass											Date from (YYYYMMDD) Date to (YYYYMMDD)		
				16. DOB (YYYYMMDD)			17. GENDER		18. PAY GRADE		19. FLIGHT STATUS <input type="checkbox"/> Yes <input type="checkbox"/> No				

20. MOST SEVERE INJURY (See Instructions)		a. Degree _____ Date of Death (YYYYMMDD) _____		b. Type _____		c. Body Part _____		d. Cause _____							
21. LOST TIME		ACTIVITY OF INDIVIDUAL Provide code (from list in instructions) and describe in space below.													
a. Days Hospitalized _____ b. Days lost not Hospitalized _____ c. Days Restricted _____ d. Treated in ER <input type="checkbox"/> Yes <input type="checkbox"/> No		23. ACTIVITY CODE (If activity is parachuting, complete Blk 38)		24. SPECIFIC DESCRIPTION OF ACTIVITY/TASK											
22a. OSHA Log 300 Case No.															
b. Name of Physician															
c. Name and Address of Treatment Facility															
25. PERSONAL PROTECTIVE EQUIPMENT		AVAILABLE?		USED?		N/A		26. ALCOHOL/DRUGS CAUSE/CONT		27. EQUIP THIS PERSON WAS ASSOCIATED WITH?					
CHECK APPROPRIATE BLOCK(S)		Yes	No	Yes	No			<input type="checkbox"/> Yes BAC % _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown		(Enter Item No. from Blk 9)					
<input type="checkbox"/>	a. Seat Belt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		28a. LICENSED TO OPERATE EQUIPMENT		28b. MANDATORY 4hr TRAFFIC SAFETY TRAINING					
<input type="checkbox"/>	b. Restraint System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____					
<input type="checkbox"/>	c. Goggles/glasses/visor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		28c. MSF CERTIFIED		29. DUTY HOURS					
<input type="checkbox"/>	d. Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____		a. Time work began (e.g., 0645): _____					
<input type="checkbox"/>	e. Ear Plugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		30. HRS SLEEP LAST 24		b. Continuous hours: _____					
<input type="checkbox"/>	f. IBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				31. TACTICAL TRAINING		32. TYPE TRAINING FACILITY			
<input type="checkbox"/>	g. Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		33. LAST TRAINING					
<input type="checkbox"/>	h. Helmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		34. FIELD EXERCISE/NAMED OPERATION <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide name: _____							
		DOT Approved (if Motorcycle) ? Yes <input type="checkbox"/> No <input type="checkbox"/>		35. NIGHT VISION SYSTEM USED <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide type: _____											
36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED/CONTRIBUTED TO ACCIDENT OR SEVERITY OF INJURY/DAMAGE? In Blk a, indicate if individual made a mistake. If yes, provide the code (from instructions) in Blk b and describe in Blk c.															
a. Mistake <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Tell what the mistake was and how it caused/contributed to the accident or serverity of injury/damage.													
b. Code															
37. WHY WAS THE MISTAKE MADE? (ROOT CAUSE) (Check the root cause(s) in Blk a. In Blk b, tell how the root cause(s) led to the mistake.)															
a.	LEADER (Not ready, willing, or able to enforce standards)	TRAINING (Insufficient in Content/Amount)		STDS/PROCEDURES (Not clear/Not practical)			SUPPORT (Shortcomings in type, capability, amount or condition of equip/supplies/services/facilities)			INDIVIDUAL (Mistake due to own personal factors)					
<input type="checkbox"/>	Direct Supervision	<input type="checkbox"/>	School	<input type="checkbox"/>	AR	<input type="checkbox"/>	SOP	<input type="checkbox"/>	Equip/Materiel Improperly Designed	<input type="checkbox"/>	Inadequate Manufacture	<input type="checkbox"/>	Poor/Bad Attitude	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Unit Command Supervision	<input type="checkbox"/>	Unit	<input type="checkbox"/>	TM	<input type="checkbox"/>	Other	<input type="checkbox"/>	Equip/Materiel Not Provided	<input type="checkbox"/>	Inadequate Maintenance	<input type="checkbox"/>	Overconfident	<input type="checkbox"/>	Alcohol, Drugs
<input type="checkbox"/>	Higher Command Supervision	<input type="checkbox"/>	Experience, OJT	<input type="checkbox"/>	FM	<input type="checkbox"/>	None exists	<input type="checkbox"/>	Inadequate Facilities/Services	<input type="checkbox"/>	Other	<input type="checkbox"/>	In a Hurry	<input type="checkbox"/>	Fear/Excitement

37b. Describe root cause(s) (*reason*) and tell how it/they caused the mistake.

38. PARACHUTE INFORMATION FOR PERSON LISTED IN Bk 11.

a. Jumper Height	g. Wind Direction/Speed at	m. Type of Last Jump	39. ENVIRONMENTAL CONDITIONS a. Present: #1 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk #2 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk #3 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk b. Caused/Contributed: #1 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk #2 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk #3 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
b. Jumper Weight	Jump Height                  Drop Zone	n. Number of Previous Jumps	
c. Type of Jump	h. Jump Altitude	o. Date Graduated Basic Airborne Training (YYYYMMDD)	
d. Parachute Type/Model	i. Position in Stick		
e. Equipment	j. Door Exited	p. Type Aircraft	
	k. Time Pre-jump Conducted	q. Accident Factors (parachute): ( <i>Explain as necessary</i> )	
f. Wt. of Equipment	l. Date of Last Jump		

40. PROVIDE BRIEF SYNOPSIS OF ACDT (*Use additional sheets if required*)(*Explain sequence of events, tell how acdt happened.*)

41. CORRECTIVE ACTION(S) TAKEN OR PLANNED

42. EXPLOSIVE/AMMUNITION INFORMATION	ITEM 1	ITEM 2	ITEM 3	ITEM 4
a. Lot#				
b. Quantity				
c. Net Explosive Weight ( <i>NEW</i> )				
d. DoDIC/DoDAC				

43. POINT OF CONTACT INFORMATION ON THE ACCIDENT

a. Name ( <i>Last, First, MI</i> ), Rank Position/Title		b. Telephone No.    DSN: _____		
		COM: _____		
		c. Email Address: _____		
44. COMMAND REVIEW	a. Name	b. Signature	c. Rank	d. Date (YYYYMMDD)
45. SAFETY OFFICE REVIEW	a. Name, Rank & Title			b. Phone Number
c. Email Address		d. Date Reviewed (YYYYMMDD)		e. Local Report No. ( <i>Safety Office use only</i> )