



CUI



MISHAP DATA SHEET

Ver 3

Complete 1-8 hours after any Army Mishap. Return sheet to Unit/Directorate level Safety Officer. **USO forward to GSO ASAP.**

Personal Information		Mishap Details	
Grade/Name of injured or equipment operator		Explosives or Ammunition <input type="checkbox"/> Present <input type="checkbox"/> Not-present	
Age/Gender	/ Male ___ Female	<input type="checkbox"/> Combat <input type="checkbox"/> Non-Combat / <input type="checkbox"/> Tactical Training	
Unit		<input type="checkbox"/> METL task <input type="checkbox"/> Non-METL / <input type="checkbox"/> Sergeants Time Training	
Home Address (Civilian Only)		Was a Deliberate Risk Management Worksheet (DDForm2799) completed on the mission/activity?: ___ Yes (<u>attach to this form</u>) ___ No	
DoDID# / MOS	/	Mishap Scene	
Date Assigned / Hired	/	<input type="checkbox"/> On Post / Name of Installation _____ / <input type="checkbox"/> Off Post _____	
Date of Birth		<input type="checkbox"/> Day <input type="checkbox"/> Night / Exact mishap location:	
Ever deployed?	If 'yes' returned when? _____	Night Vision system <input type="checkbox"/> used Not used <input type="checkbox"/> N/A	
Mishap Date/Time	Date _____ Time _____	Describe Weather : (<i>Rain, cold, dark, etc</i>)	
Duty Status	___ ON ___ OFF	Photos Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No (Securely forward photos of the Mishap Scene)	
Hours on duty/ Hours of sleep	___ On Duty ___ hrs Sleep night before	Injury Info	
Protective Gear Available?	___ Yes ___ No (Type: _____)	<input type="checkbox"/> Eyes L/R <input type="checkbox"/> Leg L/R <input type="checkbox"/> Knee L/R <input type="checkbox"/> Ankle L/R <input type="checkbox"/> Arm L/R <input type="checkbox"/> Hand L/R (Indicate L or R: _____)	
Protective Gear Worn?	Yes No	<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> 2 or more injured people (Complete an MDS for each person involved)	
		Place of Treatment: _____ ER: <input type="checkbox"/> Yes <input type="checkbox"/> No Dr. Name: _____	

Mishap Involved:		Damage to Vehicle (check all applicable) / License & Cert information			
<input type="checkbox"/> Tactical Vehicle <input type="checkbox"/> TMP <input type="checkbox"/> Motorcycle <input type="checkbox"/> POV		<input type="checkbox"/> Frame <input type="checkbox"/> Doors <input type="checkbox"/> Head or Tail lights <input type="checkbox"/> Windows <input type="checkbox"/> Windshield			
<input type="checkbox"/> Physical Training (Type: _____)		<input type="checkbox"/> Front bumper/grill <input type="checkbox"/> Rear bumper			
<input type="checkbox"/> Org. Sports <input type="checkbox"/> Sports (Type: _____)		<input type="checkbox"/> Tire(s) <input type="checkbox"/> Axle(s) <input type="checkbox"/> Roof <input type="checkbox"/> Other _____			
<input type="checkbox"/> Falling /From what?		Equipment Operator : licensed Y N			
<input type="checkbox"/> Equipment:		Date of last Tng / License Issue date: _____ /			
Veh/Equipment Type: _____ Make&Model: _____		Vehicle Cdr (VC) : VC Card Y N			
VIN/Serial#: _____		MSF Certification Date: _____ (Motorcycles only)			
Follow up W/N 24hrs: _____	Estimated Cost of Damage: _____	Days Hospitalized: _____	Days Qtrs: _____	Days Restricted: _____	Days Transferred: _____
Contributing Factors: (Human Error, SOP shortcoming, Procedures not followed, Equipment; "X" ALL possible Root Causes)					
Leader	Training	Standards	Equipment	Individual	
<input type="checkbox"/> Direct Supervision	<input type="checkbox"/> School	<input type="checkbox"/> AR <input type="checkbox"/> SOP	<input type="checkbox"/> Failure <input type="checkbox"/> Maintenance	<input type="checkbox"/> Attitude <input type="checkbox"/> Fatigue	
<input type="checkbox"/> Unit Supervision	<input type="checkbox"/> Unit	<input type="checkbox"/> TM <input type="checkbox"/> Other	<input type="checkbox"/> Missing <input type="checkbox"/> Manufacturer	<input type="checkbox"/> Overconfident <input type="checkbox"/> Fear	
<input type="checkbox"/> Higher command	<input type="checkbox"/> Experience	<input type="checkbox"/> FM <input type="checkbox"/> No SOP	<input type="checkbox"/> Facility <input type="checkbox"/> Other	<input type="checkbox"/> In a hurry <input type="checkbox"/> Alcohol/drugs	

Synopsis of the Mishap (Use the back if needed):

POC info

Rank/Name of person completing this sheet: _____ Work # _____ Cell# _____

Rank/Name of Vehicle Commander: _____ Work # _____ Cell# _____

Rank/Name of Mishap Witness #1: _____ Work # _____ Cell# _____

Deliver to USO/Supervisor/GSO-ASAP!

Form POC: USAG FS Safety Office (571) 801-2058/2050/2055/2054 or HAAF (571) 801-7539

Email: usarmy.stewart.usag.list.gso-all@army.mil

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