



AUSTRALIAN BALLOONING FEDERATION INC.

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CONFIDENTIAL INCIDENT / ACCIDENT REPORT				PAGE 1 OF 2	
Report No.					
Incident			Balloon		
Date	Time	Registration	Type/Size		
Location		Address or Grid reference (Map sheet number)			
Pilot Name			Number of flying hours		
Student Name			Number of flying hours		
Passenger Names					
Complete this section in cases where injury sustained (photocopy and append for additional persons)					
Name of injured			Age	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Phone No.
Nature of injury			Part of body injured		
<input type="checkbox"/> Fracture	<input type="checkbox"/> Superficial	<input type="checkbox"/> Burn	<input type="checkbox"/> Head	<input type="checkbox"/> Leg	<input type="checkbox"/> Hernia
<input type="checkbox"/> Laceration	<input type="checkbox"/> Sprain	<input type="checkbox"/> Amputation	<input type="checkbox"/> Eyes	<input type="checkbox"/> Feet	<input type="checkbox"/> Multiple
<input type="checkbox"/> Strain	<input type="checkbox"/> Confusion	<input type="checkbox"/> Multiple	<input type="checkbox"/> Ears	<input type="checkbox"/> Toes	<input type="checkbox"/> General
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Concussion	<input type="checkbox"/> Other	<input type="checkbox"/> Trunk	<input type="checkbox"/> Arms	<input type="checkbox"/> Unspecified
Description of injury			<input type="checkbox"/> Back	<input type="checkbox"/> Hands	
			<input type="checkbox"/> Neck	<input type="checkbox"/> Fingers	
			Side indicator		
			<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both
Phase of operation – Please tick					
<input type="checkbox"/> Fuelling	<input type="checkbox"/> Take off		<input type="checkbox"/> Intermediate Take off		
<input type="checkbox"/> Laying out	<input type="checkbox"/> In (level) flight		<input type="checkbox"/> Final approach		
<input type="checkbox"/> Inflation	<input type="checkbox"/> Intermediate approach		<input type="checkbox"/> Final landing		
<input type="checkbox"/> Weighing off	<input type="checkbox"/> Intermediate landing		<input type="checkbox"/> Deflation		
Description of balloon damage					
Description of any third party property damage					
Is an insurance claim likely to be made? <input type="checkbox"/>					
Has incident/accident been reported to any other body? eg ATSB <input type="checkbox"/> if so, to whom?					

Details: Give a full description of the incident/accident including a sketch if appropriate

Sketch

Your comments, what may have caused the event or what may have prevented it

This section is confidential, it is required for confirmation and validity

Signed.....Date.....

Name and address (please print)

Contact telephone numbers