

Instruction Sheet – AC Mishap Report, AC Form 3900-11

AC Form 3900-11, AC Mishap Report, shall be completed for all work-related mishaps. Questions concerning completion of this form may be directed to AMP-100A, ext. 43503.

Employee Information Notes:

- Provide all requested information for the employee involved in the incident.
- For the “Duty Location” block, enter the facility where the employee normally reports to work, MMAC, ANC LSMS, BTL LSMS, etc.
- If more than one employee was involved in the incident, complete a separate form for each.
- For the “Employee Category” block, select from the following: Full Time, Part Time, Contractor, Summer Hire, or Stay in School.

Incident Information Notes:

- Complete all information applicable to the incident.
- The “Task being performed” block should discuss the general work-related task the employee was performing when the incident occurred even if the employee was away from their usual work area; e.g., “Walking from the LSF to the Headquarters Building to attend a meeting”.
- The “Specific Location” block should include the building name or number and room or shop where the incident occurred. For incidents that occur outdoors, provide the location in reference to the nearest building; e.g., “In the parking lot north of the Registry Building.”
- The “Detailed Incident Description” block should contain a clear, concise narrative overview of the incident as it occurred. Also, answer “yes/no/NA” as applicable to each of the items below the block and provide additional information if necessary.

Injury/Illness/First Aid Information:

Injury or Hazard Events: Select the choice below most appropriate to the mishap.

N/A	Fall on same level
Bodily Reaction	Motor Vehicle Accident
Caught In/Under/Between	Overexertion
Contact with Caustics	Public Transportation Accident
Contact w/Electric Current	Rubbed/Abraded
Contact w/Radiation	Struck Against
Contact w/Temperature Extremes	Struck by
Contact w/Toxic Substances	Other (Specify)
Fall from elevation	

Injury Type: Select the choice below most appropriate to the mishap.

N/A	Dermatitis	Inflammation
Amputation	Dislocation	Multiple Types
Asphyxia	Electronic Shock/Electrocution	Near Miss
Burn/Chemical	First Aid	Poisoning
Burn/Heat	Fracture	Radiation
Concussion	Freezing/Frostbite	Scratch/Abrasion
Contusion/Crush/Bruise	Hearing Loss	Sprain/Strain
Contusion/Crush/Cuts	Heat Stroke	Unknown
Cut/Puncture	Hernia/Rupture	Other (Specify)

Illness Type: Select the choice below most appropriate to the mishap.

N/A Contagious Infectious Disease Dermatitis Disorders Associated with Repeated Trauma Disorders due to Physical Agents Dust Disease of the Lungs Occupational Disease	Occupational Skin Disease or Disorders Pneumoconiosis Poisoning-Systemic Effects Toxic Material Respiratory Condition Due to Toxic Agents Unknown Other (Specify)
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Body Part: List the effected body part (arm, finger, leg, head, etc.).

Injury Source: Select the primary source below most appropriate to the mishap.

N/A Air Pressure Animal Products Animals/Insects Bodily Motion Boilers/Valves Boxes/Containers Buildings/Structures Ceramics Clothing Coal/Petroleum Products Cold Computer Conveyors Drugs/Medicine Electricity	Fire/Smoke Food Products Furniture Glass Hand Tools (non-powered) Hand Tools (powered) Heat Ice and Snow Inclement Weather Infectious Agents Ladders Liquids Machines Mechanical Power Transmission Metal (Molten/Ingots/Scrap)	Minerals-Metallic Minerals-Non-Metallic Noise Paper Particles Plants/Vegetation Plastics Pumps Radiating Substances Scrap/Debris/Wastes Silica Soap/Detergents/Cleansers Steam Textiles Unknown Other (Specify)
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Hazard Source: Select the choice below most appropriate to the mishap.

Defect of Agencies Dress or Apparel Hazards Environmental Hazards Equipment Inadequately Guarded Hazardous Methods or Procedures Hazardous Outside Work Environment Improper Work Procedures	None Personal Protective Equipment not Available Personal Protective Equipment not Used Placement Hazard Public Hazards Unknown Other (Specify)
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If there is a secondary injury/illness as a result of the first, such as a fall from an elevation after an electrical shock resulting in additional injury, provide the applicable information in the blocks provided.

Medical Assistance Information Notes:

- The applicable additional forms listed must also be completed if medical assistance or lost time occurs or is anticipated.
- If the employee is still off work or on restricted duty when the form is submitted, list the number of days since the incident (the remainder of the day the incident occurred is not counted as lost/restricted) and note "pending" in the date block.

Aeronautical Center Mishap Report

This form shall be completed for all work-related mishaps. Supervisors shall ensure that all applicable information has been included on the form and forward it to AMP-100A within five working days of the incident.

Employee Information

Duty Location: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Sex: _____

Job Series/Title: _____ Routing Symbol: _____

Supervisor Name: _____ Employee Category: _____

Supervisor Phone: _____ Travel Status: _____ (yes or no)

_____ Years in Current Job Series _____ Years of FAA Employment

Incident Information

_____ Illness: Generally associated with chronic symptoms or exposures. _____ Property Damage

_____ Injury: Generally associated with a single event or exposure. _____ Motor Vehicle

_____ First Aid: An injury that does not require professional medical attention. _____ Near Miss

Incident Date: _____ Time: _____ am/pm

Specific Location: _____

Task being performed: _____

Sub-task being performed: _____

Detailed Incident

Description: Narrative and discuss, if necessary, all of the following information applicable to the situation.

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|---|--|
| _____ Was personal protective equipment used (if applicable)? | _____ Was fatigue a factor? |
| _____ Were individuals properly trained, including safety training? | _____ Were drugs or alcohol involved? |
| _____ Phase of Operation (if applicable). | _____ Were any other human factors involved? |
| _____ Specify equipment involved. | _____ What shift were the employees working? |
| _____ Name of individual operating equipment, if other than listed. | _____ List possible contaminants (if applicable). |
| _____ Operator experience level with equipment involved. | _____ Number of personnel exposed (if applicable). |
| _____ Total experience level(s) of parties involved. | _____ Was weather/environmental conditions a factor? |
| _____ Was employee working alone? If not, crew size was _____. | _____ Were employees performing usual job task(s)? |

Suspected Cause: _____

Corrective Action Taken/Required: _____

Witness Name: _____ Phone Number: _____

2nd Witness Name: _____ Phone Number: _____

Injury/Illness/First Aid Information:

*Injury or Hazard Event(s): _____
*Injury or Hazard Event: Select the choice from the instruction sheet most appropriate to the mishap.
**Injury/Illness Type: _____ Body Part: _____
**Injury/Illness Type: Select the choice from the instruction sheet most appropriate to the mishap.
***Injury or Hazard Source: _____
***Injury or Hazard Source: Select the choices from the instruction sheet most appropriate to the mishap.
2nd Injury/Illness Type: _____ Body Part: _____
2nd Injury/Hazard Source: _____

Medical Assistance Information:

_____ Medical Authorization: Form CA-16 _____ Lost/Restricted Days Incurred
_____ For Injuries: Submit Form CA-1 _____ For Illnesses: Submit Form CA-2

****Description of Medical Treatment Obtained or Required for Illness:

****Include physician name and/or hospital name, address, and phone number, if available.

_____ Number of Days Away from Work _____ Date Employee Returned to Work
_____ Number of Days of Restricted Work _____ Date Restrictions were Lifted
_____ Fatality _____ Date of Death

Property Damage Information:

_____ Property Damage: Submit AC Form 1600-5

Description of Damage to FAA Property: _____

Description of Damage to Non-FAA Property: _____

_____ Non-FAA Property Damage Cost _____ FAA Property Damage Cost

Motor Vehicle Information:

_____ Submit Standard Form 91 - Motor Vehicle Accident Report
_____ Submit Standard Form 94 - Statement of Witness

_____ Vehicle 1 Damage Cost _____ Were Seat Belts in Use?
_____ Vehicle 1 Make _____ Vehicle 1 Tag Number
_____ Vehicle 1 Model and Year _____ State
_____ Vehicle 2 Damage Cost _____ Were Seat Belts in Use?
_____ Vehicle 2 Make _____ Vehicle 2 Tag Number
_____ Vehicle 2 Model and Year _____ State