

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT (AGAR)

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 | |
| #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 | |

| | | | | | | | | | | | | | | |
|--|--|--|---|----|---|-------------|--------------------------|---|--------------------------|-------|--|------------------------------------|--------------------------|------------------------|
| 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 |
| | | | 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? (Enter Item No. from Blk 9) | | | | | | |
| CHECK APPROPRIATE BLOCK(S) | | Yes | No | Yes | No | | <input type="checkbox"/> Yes BAC % _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | |
| <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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | 28b. MANDATORY 4hr TRAFFIC SAFETY TRAINING <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____ | | | | | | |
| <input type="checkbox"/> | b. Restraint System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| <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 <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____ | | 29. DUTY HOURS a. Time work began (e.g., 0645): _____ b. Continuous hours: _____ | | | | | | |
| <input type="checkbox"/> | d. Gloves | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| <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 | | 31. TACTICAL TRAINING <input type="checkbox"/> Yes <input type="checkbox"/> No | | 32. TYPE TRAINING FACILITY | 33. LAST TRAINING | | | |
| <input type="checkbox"/> | f. IBA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| <input type="checkbox"/> | g. Other (Specify) | <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: _____ | | 35. NIGHT VISION SYSTEM USED <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide type: _____ | | | | | | |
| <input type="checkbox"/> | h. Helmet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| | | DOT Approved (if Motorcycle) ? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | |
| 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 BIK 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: _____ |

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|--------------------|---------|--------------|---------|--------------------|
| 44. COMMAND REVIEW | a. Name | b. Signature | c. Rank | d. Date (YYYYMMDD) |
|--------------------|---------|--------------|---------|--------------------|

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|--------------------------|-----------------------|-----------------|
| 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>) |
|------------------|-----------------------------|---|