TECHNICAL REPORT OF U.S. ARMY AIRCRAFT ACCIDENT
PART X - INJURY/OCCUPATIONAL ILLNESS DATA

For use of this form, see DA Pamphlet 385-40; the proponent agency is OCSA.

REQUIREMENTS CONTROL SYMBOL
CSOCS-309

1. DEGREE OF INJURY *(Check only the most severe injury)*

a. ☐ Fatal
b. ☐ Permanent Total Disability
c. ☐ Permanent Partial Disability
d. ☐ Days Away From Work
e. ☐ Restricted Work Activity
f. ☐ Medical Treatment Above First Aid
g. ☐ First Aid Only
h. ☐ Missing and Presumed Dead

2. NUMBER OF LOST WORKDAYS	a. Days Away From Work	b. Days Hospitalized	c. Days of Restricted Activity

3. UNCONSCIOUS	Hrs	Min	☐ None	**4. AMNESIA**	Hrs	Min	☐ None

5. INJURIES		Injuries			Mechanism		Cause Factors		
Seq No. a.	Body Region b.	Primary Aspect c.	Secondary Aspect d.	Inj Type/Result e.	Action f.	Qualifier g.	Subject h.	Action i.	Qualifier j.

6. REMARKS *(Use additional sheet if required)*

7. AUTOPSY PERFORMED ☐ Yes ☐ No	**8. CAUSE OF DEATH / DATE OF DEATH**	**9. DUTY STATUS** ☐ On Duty ☐ Off Duty

10. NAME *(Last, First, MI)*	**11. SSN**	**12. GRADE**	**13.GENDER**	**14. DUTY**

15a. SVC	b. HOME ADDRESS	c. DOB *(YYYYMMDD)*	d. DATE HIRED *(YYYYMMDD)*

e. TIME EMPLOYEE BEGAN WORK	f. WAS EMPLOYEE TREATED IN EMERGENCY ROOM? ☐ Yes ☐ No	g. ADDRESS & NAME OF HOSPITAL
h. ATTENDING PHYSICIAN	i. LOG NUMBER / **16. UIC**	

17. CASE NO.	a. Date *(YYYYMMDD)*	b. Time	c. Acft Serial No.	**18. OTHER ACFT SERIAL NO.**	**19. INJURY COST**