

NON-ROUTINE INCIDENT REPORT



Instructions: Print or type in black ink. Use of this form supplements two-hour oral notification of a non-routine incident. This form must be completed and submitted to the appropriate DEC Oil and Gas Regional Minerals Manager (see well permit or <https://www.dec.ny.gov/energy/205.html>) within twenty-four (24) hours of discovery of the incident. If an Interim Report is submitted, it must always be followed by a Final Report filed at a later date. Completion and submittal of this report form fulfills only ECL Article 23 and 6 NYCRR Parts 550 – 559 reporting requirements. The owner or operator must also comply with any other applicable statutes and regulations of the Department, including reporting to the DEC Spill Hotline if required. For additional assistance with completing this form, contact the appropriate Regional office.

WELL NAME AND NUMBER OR FACILITY (only provide facility if incident not associated with well)	API WELL IDENTIFICATION NUMBER <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; border: 1px solid black; text-align: center;">31</td> <td style="width:10%; border: 1px solid black;"></td> <td style="width:10%; border: 1px solid black; text-align: center;">-</td> <td style="width:10%; border: 1px solid black;"></td> <td style="width:10%; border: 1px solid black; text-align: center;">-</td> <td style="width:10%; border: 1px solid black;"></td> <td style="width:10%; border: 1px solid black; text-align: center;">-</td> <td style="width:10%; border: 1px solid black;"></td> <td style="width:10%; border: 1px solid black;"></td> <td style="width:10%; border: 1px solid black;"></td> </tr> </table>	31		-						-						-			
31		-						-						-					
NAME OF OWNER (Full Name of Organization or Individual as registered with the Division)	OWNER'S ADDRESS (P.O. Box or Street Address, City, State, Zip Code)																		
TELEPHONE NUMBER (include area code)																			

1. TYPE OF REPORT

Interim Check "Interim" if event is ongoing **OR** if all associated spill/release and recovery operations have not been completed **OR** if incident reporter is not an Authorized Representative listed in Box 7 of the owner's Organization Report on file with DEC.

Final Check "Final" if event has ceased **AND** all associated spill/release and recovery operations have been completed **AND** incident reporter is an Authorized Representative listed in Box 7 of the owner's Organizational Report on file with DEC.

2. LOCATION OF INCIDENT County: _____ Town: _____

Decimal Latitude (NAD 83):

Decimal Longitude (NAD 83):

3. INCIDENT OCCURRENCE Date _____ Time _____ AM/PM _____

Estimated or Known (check appropriate box) _____ / _____ / _____ : _____

4. INCIDENT DISCOVERY Date _____ Time _____ AM/PM _____

_____ / _____ / _____ : _____

5. INCIDENT INITIALLY CONTROLLED Date _____ Time _____ AM/PM _____

_____ / _____ / _____ : _____

6. TYPE OF INCIDENT (check all boxes that describe incident)

Surface Blowout Fire Spill/Release Downhole , specify: _____

Other , specify: _____

7. ASSOCIATED SPILL/RELEASE AND RECOVERY (as of this report date)

Fluid Type	Total Volume Released (check appropriate box)	Total Volume Recovered (check appropriate box)
Oil	Bbls Estimated <input type="checkbox"/> or Known <input type="checkbox"/>	Bbls Estimated <input type="checkbox"/> or Known <input type="checkbox"/>
Brine	Bbls Estimated <input type="checkbox"/> or Known <input type="checkbox"/>	Bbls Estimated <input type="checkbox"/> or Known <input type="checkbox"/>
Gas	Mcf Estimated <input type="checkbox"/> or Known <input type="checkbox"/>	Mcf Estimated <input type="checkbox"/> or Known <input type="checkbox"/>
Other (specify)	Estimated <input type="checkbox"/> or Known <input type="checkbox"/>	Estimated <input type="checkbox"/> or Known <input type="checkbox"/>

8. Estimated area affected (sq. ft.) _____

Was any surface water affected? Yes No
If "Yes," describe _____

Was there any personal injury? Yes No
If "Yes," describe _____

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9. Detailed Description of Incident (check box if additional page(s) attached) :

10. Description of Initial Corrective Actions (check box if additional page(s) attached) :

11. Description of Proposed Corrective Action Plan (CAP). If additional time is requested to formulate the CAP, state so below and include a time frame for submittal of the CAP. (check box if additional page(s) attached) :

12. Agency Name, Staff Name, Date and Time of Other Notification(s) to NYSDEC Divisions and/or Other Local, State and Federal Agencies (check box if additional page(s) attached) :

Printed or Typed Name and Affiliation of Incident Reporter or Authorized Representative (see below note)

Signature of Incident Reporter or Authorized Representative (see below note)

Date

____ / ____ / ____

Note: Only an Authorized Representative listed in Box 7 of the Organizational Report on file with the Division of Mineral Resources may sign a "Final" report.