DIVISION OF MINERAL RESOURCES

NON-ROUTINE INCIDENT REPORT

PRINT

NEW YORK STATE | Department of Environmental Conservation

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 office (see well permit or visit the Division's website) 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 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 report filer 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 ☐ or Known ☐	Bbls	Estimated ☐ or Known ☐
Brine	Bbls	Estimated ☐ or Known ☐	Bbls	Estimated ☐ or Known ☐
Gas	Mcf	Estimated ☐ or Known ☐	Mcf	Estimated ☐ or Known ☐
Other (specify)		Estimated ☐ or Known ☐		Estimated ☐ or Known ☐

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)

The use of an electronic signature below indicates the signer's intent to sign the document and is the legal equivalent of having placed a handwritten signature on this form.

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.