

INCIDENT REPORT



Site/Venue of accident: <i>Exact location overleaf...</i>			
Address:			
Phone:		Fax No:	
		Email:	
Contact Person:			Date of Incident:

Time of Accident:		Horse Name		<input type="checkbox"/>	Own Horse
				<input type="checkbox"/>	Hired Horse
Weather conditions:					

Staff member(s) in charge of and/or supervising injured party:		Numbers under supervision:		
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INJURED PERSON DETAILS:

Name:				
Address:				
Phone:		Date of Birth:		Experience in riding
				<i>Beginner/moderate/experienced</i>

ACCIDENT OCCURRED WHILE:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Mounting | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Dismounting |
| <input type="checkbox"/> Unmounted activity | <input type="checkbox"/> Jumping in Arena | <input type="checkbox"/> |
| <input type="checkbox"/> Flat work/Dressage | <input type="checkbox"/> Trail Ride | |

INJURY LOCATION:

<input type="checkbox"/> Head (Skull, Face, Jaw, Ears)	<input type="checkbox"/> Eyes	<input type="checkbox"/> Neck
<input type="checkbox"/> Trunk (Chest, Abdomen, Buttock, Pelvis)	<input type="checkbox"/> Spine	<input type="checkbox"/> Arm (Shoulder, Elbow, Forearm, Wrist, Hand, Finger, Thumb)
<input type="checkbox"/> Leg (Hip, Thigh, Knee, Ankle, Foot, Toe)	<input type="checkbox"/> Internal	<input type="checkbox"/>

INJURY SEVERITY:

<input type="checkbox"/> First Aid (Continued to ride)	<input type="checkbox"/> First Aid (Went home)	<input type="checkbox"/> First Aid (sought medical attention after leaving)
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Doctor's or Dental Treatment	<input type="checkbox"/> Hospital Treatment (Admittance)
<input type="checkbox"/> Fatal	<input type="checkbox"/>	

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WITNESS DETAILS:

Name:			
Address:			
Phone:		Date of Birth:	
		<input type="checkbox"/> Staff member <input type="checkbox"/> Volunteer/Other rider <input type="checkbox"/>	

ACCIDENT SUMMARY

Description of accident, exact location, observations of signs and symptoms of injuries, treatment and follow up; include times and names of those involved in treatment at all stages.

Signed:

Date:

- Please find attached a signed waiver
- Please find attached photos taken
- Please find attached supporting documentation