



ACCIDENT REPORT



AFFILIATE NAME: _____

Site/Venue of accident: _____
Exact location overleaf...

Address: _____

Phone: _____ **Fax No:** _____ **Email:** _____

Contact Person: _____ **Date of Accident:** _____

Time of Accident: _____

Horse Name _____

- own
 hired

Weather conditions:

Staff member(s) in charge of and/or supervising injured party:

Numbers under supervision:

INJURED PERSON DETAILS:

Name: _____

Address: _____

Phone: _____ **Date of Birth:** _____ **Experience in riding:** _____
Beginner/moderate/experienced

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"/> If other please detail |
| <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"/> If other please detail |

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"/> Other (please detail) | |

