

## Accident Report

<b>Date of Accident:</b>	<input style="width: 95%;" type="text"/>
<b>Time of Accident:</b>	<input style="width: 95%;" type="text"/>
<b>Weather conditions:</b>	<input style="width: 95%;" type="text"/>
<b>Activity:</b>	<input style="width: 95%;" type="text"/>

### INJURED PERSON DETAILS:

<b>Name:</b> <input style="width: 95%;" type="text"/>			
<b>Address:</b> <input style="width: 95%;" type="text"/>			
<b>Phone:</b> <input style="width: 20%;" type="text"/>	<b>Fax No:</b> <input style="width: 20%;" type="text"/>	<b>Date of Birth:</b> <input style="width: 20%;" type="text"/>	<input style="width: 40%;" type="text"/>

### ACCIDENT ACTIVITY:

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Mounting           | <input type="checkbox"/> Dismounting | <input type="checkbox"/> Trail Ride    |
| <input type="checkbox"/> Flat work Riding   | <input type="checkbox"/> Jumping     | <input type="checkbox"/> Cross Country |
| <input type="checkbox"/> Unmounted Activity | <input type="checkbox"/> Other       |  |

If other please detail

Indemnity Signed? YES /NO


### 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 | Other 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                        |   |

