



INCIDENT REPORT FORM

This form must be completed by a club official at the time of an accident, injury or other incident during a club sanctioned, organized and/or supervised activity. Please forward the form to Gymnastics NL within 2 days of the accident/ incident.

Submit Completed form to:
GymnasticsNL
1296 Kenmount Road
Paradise, NL
A1L 1N3
cheffernan@sportnl.ca
Fax: (709) 576-7493

SECTION A: INJURED		<input type="checkbox"/> GYMNAST	<input type="checkbox"/> COACH	<input type="checkbox"/> SPECTATOR	<input type="checkbox"/> OTHER
First Name:	Last Name:	Registration #:			
Address:	City:	Province:	Postal Code:		
Phone#:	DOB (d/m/y):	Years of Experience:			
Name of Coach at Time of Accident:		Coach Phone #:			
NCCP#:	Level of Coach Training: Foundations <input type="checkbox"/> Artistic <input type="checkbox"/> Trampoline <input type="checkbox"/> Active Start <input type="checkbox"/>				
Witness Name:	C1 WAG/MAG/TG <input type="checkbox"/> C2 WAG/MAG/TG <input type="checkbox"/> C3 WAG/MAG/TG <input type="checkbox"/> C4 WAG/MAG <input type="checkbox"/> (check all that apply for training or enter C in box to indicate certified. For C1 and above please specify discipline by circling all those that apply)				
Club/Site Name:					
How Long into Training/Event did Injury Occur? <input type="checkbox"/> Hours <input type="checkbox"/> Minutes 1					
Injury Occurred During: <input type="checkbox"/> Recreation Practice <input type="checkbox"/> Competitive Practice <input type="checkbox"/> Birthday Party <input type="checkbox"/> Club Sanctioned Event:					
Does the individual suffer from any disability or medical conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
If Yes, please specify: _____					
SECTION B: DETAILS OF INJURY					
Discipline: <input type="checkbox"/> Active Start <input type="checkbox"/> Men's Artistic <input type="checkbox"/> Rhythmic <input type="checkbox"/> Trampoline <input type="checkbox"/> Women's Artistic <input type="checkbox"/> Other Summer Camp					
Event / Location: <input type="checkbox"/> FIG Approved Equipment <input type="checkbox"/> Homemade Equipment FIG Brand/Type: _____		Surface (ex: mats, floor, apparatus): _____			
Describe HOW the injury happened and the skill/activity the individual was trying to attempt: _____ _____ _____ _____		Activity Involved: <input type="checkbox"/> Stretching/Conditioning <input type="checkbox"/> Element Practice <input type="checkbox"/> Approach <input type="checkbox"/> Mount <input type="checkbox"/> Dismount/Landing <input type="checkbox"/> Mid-Routine <input type="checkbox"/> Spotting <input type="checkbox"/> Other, Please Specify: _____			
		Situation: <input type="checkbox"/> Fall (slip/trip/pushed/lost balance) <input type="checkbox"/> Missed <input type="checkbox"/> Over-rotated <input type="checkbox"/> Under-rotated <input type="checkbox"/> Collision with Person <input type="checkbox"/> Collision with Other Object <input type="checkbox"/> Non-Contact Injury <input type="checkbox"/> Other, Please Specify: _____			
Injured Body Part: <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Left <input type="checkbox"/> Forearm <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Right <input type="checkbox"/> Shoulder <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Spine <input type="checkbox"/> Both <input type="checkbox"/> Buttocks <input type="checkbox"/> Hamstring <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> N/A <input type="checkbox"/> Calf <input type="checkbox"/> Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Toe		Nature of Injury: <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Concussion/Head Injury <input type="checkbox"/> Other (Please specify): _____			
Injury Classification: <input type="checkbox"/> New Injury <input type="checkbox"/> Re-injury <input type="checkbox"/> Acute injury <input type="checkbox"/> Chronic Injury <input type="checkbox"/> Recurrent Injury - Sport <input type="checkbox"/> Recurrent Injury - Non-Sport <input type="checkbox"/> Complication of Prior Injury		Initial Treatment: <input type="checkbox"/> RICE (Rest, Immobilize, Cold, Elevate) <input type="checkbox"/> CPR <input type="checkbox"/> Manual Therapy <input type="checkbox"/> Sling/Splint <input type="checkbox"/> Wrapping/Taping <input type="checkbox"/> Dressing <input type="checkbox"/> Stretch/Exercise <input type="checkbox"/> None – Referred Elsewhere			
Symptoms: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Loss of Feeling <input type="checkbox"/> Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Consciousness/Fainting* <input type="checkbox"/> Other, please specify: headache		Disposition: <input type="checkbox"/> Self-transport <input type="checkbox"/> EMS Care <input type="checkbox"/> On-Site Only <input type="checkbox"/> Hospital Care <input type="checkbox"/> Refused Care <input type="checkbox"/> Other, Please Specify: _____			
*All Loss of consciousness or fainting requires IMMEDIATE medical follow up – CALL 911		Referral: <input type="checkbox"/> Family Doctor <input type="checkbox"/> Physiotherapist <input type="checkbox"/> No Referral <input type="checkbox"/> Other, Please Specify: _____			
Clubs should FOLLOW UP after the Incident and Report Results, if applicable:					
Date of Injury (d/m/y): Time of Occurrence: _____: _____ (am / pm)		Current Date (d/m/y):			
Club Official:		Signature:			
<p>*Sport Accident Insurance is provided for members registered with GymnasticsNL for "out of pocket medical expenses" due to a sustained injury while participating in a sanctioned activity. Refer to the BFL Claim Form. Claims must be supported by the initial Incident Report. Claims not supported by incident reports will not be considered. ***Please do not forward this form to BFL ***</p> <p>**Any personal information collected on this form is strictly confidential and will not be disclosed to a third party</p>					