

2020 FIRST REPORT OF INCIDENT

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Event Name:	
Event Dates:	
City:	ST
# of participants:	



(Signature)

experience the edge -☐ Check here if no incidents occurred DATE OF INCIDENT_____TIME OF INCIDENT_ AM/PM DOES THE INJURED PERSON HAVE OTHER MEDICAL _____PHONE RACE DIRECTOR **INSURANCE?** \square YES \square NO Name of Company/Club/Organization: If yes, please provide name of company and policy **USAT MEMBERSHIP STATUS:** □ ANNUAL □ ONE DAY DID THIS TAKE PLACE DURING: (check all that apply) □ PRO ☐ AGE GROUP □ Practice □ Competition □ Club activity □ Pre-activity ☐ Sanctioned event □During activity □ After activity INJURED PERSON: ☐ Official ☐ Coach ☐ While traveling ☐ Athlete ☐ Spectator ☐ Employee ☐ Volunteer IF DURING EVENT, WHICH DISCIPLINE? Other ___ □ Swim □ Run □ Bike □ Transition INJURED PERSON INFORMATION: Telephone Number () Middle ☐ Single Last **First** ☐ Married Address State Zip ☐ Male ☐ Female **Employer and Address:** GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR) Middle Telephone Number (Last **First** Address State Zip INCIDENT LOCATION INCIDENT MEDICAL SERVICES Competition area

Off property Assault/Sexual Drug Testing Antacid Eye rinse Slip, bodily reaction ☐ Trip/Fall Aspirin Parking lot Store area Glucose ☐ Bleachers/stands Admission area Assault/Non-Sexual Overexertion Aspirin substitute Ice Pack Restrooms/locker ☐ Premises/ground Slip/Fall Eligibility Bandaged Oxygen Fall (different level) ☐ Aquatic Ointment/antiseptic Splinted rooms Fall (same level) Wrapped OTHER: Rest Collision (with object) Removal Exam Collision (participant/participant) CPR Cold Pack CLASSIFICATION Collision (participant/spectator) Cleansed Facility or event related Non-injury Not facility or event related Collision (spectator/spectator) Other: Caught in, on, between Minor injury or illness Struck by falling/flying object Serious injury or illness Treated by Auto/Property PRIMARY INJURY Animal/insect bite/sting DISPOSITION Abrasion Contusion Released to parent

Police **BODY PART INJURED** ☐ Ambulance Allergy Heat Exhaustion Refusal of care ☐ Report only Amputation Cardiac Eye (L/R) Ankle (L/R) Refer to doctor Arm (L/R) Cold Injury Stroke Nose Refer to hospital or clinic Dislocation Neck Back Medical attention Pain Drowning Tooth/Mouth Ear (L/R) Tooth EMS transport Knee (L/R) Face Patient requested EMS transport Electrical Shock Illness Foreign Body Sting/Bite Internal Head Released to personal vehicle Fracture Nausea Shoulder (L/R) Hip(L/R)Elbow (L/R) Foot (L/R) Hypertension Concussion Hand (L/R) Laceration Wrist (L/R) Burn Torso ☐ Leg (L/R) Seizure Death Strain/Sprain Describe how the incident occurred: WITNESS INFORMATION: NAME ADDRESS TELEPHONE NUMBER

NAME ADDRESS TELEPHONE NUMBER

1.
2.
Name of Race Director or Official or MD (no relationship to claimant) _______ (Print Name)