HORSE RIDING CLUBS ASSOCIATION OF VICTORIA INC.

INCIDENT REPORT

PLACE WHERE INCIDENT OCCURED:

Place:

Address:

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

Contact Person: **Date of Incident:**

Time of Incident:

Weather conditions:

Person in Charge: **Number under supervision:**

INJURED PERSON DETAILS:

Name:

Address:

Membership Number: **Phone:** **Date of Birth:**

Indemnity Signed? **YES / NO**

ACCIDENT ACTIVITY:

- ❑ Mounting
- ❑ Dismounting
- ❑ Trail Ride
- ❑ Flat work Riding
- ❑ Jumping
- ❑ Cross Country
- ❑ Unmounted Activity
- ❑ Other - please detail

INJURY LOCATION:

- ❑ Head (Skull, Face, Jaw, Ears)
- ❑ Spine
- ❑ Neck
- ❑ Trunk (Chest, Abdomen, Buttock, Pelvis)
- ❑ Arm (Shoulder, Elbow, Forearm, Wrist, Hand, Finger, Thumb)
- ❑ Eyes
- ❑ Leg (Hip, Thigh, Knee, Ankle, Foot, Toe)
- ❑ Internal
- ❑ Other - please detail

INJURY SEVERITY:

- ❑ First Aid (Continued to ride)
- ❑ First Aid (Went home)
- ❑ First Aid (sought medical attention after leaving)
- ❑ Ambulance
- ❑ Doctor's or Dental Treatment
- ❑ Hospital Treatment (Admittance)
- ❑ Fatal
- ❑ Other

WITNESS DETAILS:

Name:					
Address:					
Phone:		**Fax No:**		**Date of Birth:**	

INCIDENT SUMMARY

Signed: **Date:**

This is not an official insurance Claim Form. Any insurance claim must be made by the injured party.
Club to retain original. Copy to be forwarded to HRCAV