FIRST REPORT OF INCIDENT

Event Name: _____
Event Dates: _____- _____
City: _____ ST_____
# of participants: _____
☐ Check here if no incidents occurred

DATE OF INCIDENT_____ **TIME OF INCIDENT**_____**AM/PM**
RACE DIRECTOR _____ **PHONE** _____
Name of Company/Club/Organization:_____
Address:_____

DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? ☐ **YES** ☐ **NO**
If yes, please provide name of company and policy #:_____

USAT MEMBERSHIP STATUS: ☐ ANNUAL ☐ ONE DAY
(check all that apply) ☐ PRO ☐ AGE GROUP

INJURED PERSON: ☐ Athlete ☐ Official ☐ Coach ☐ Spectator ☐ Employee ☐ Volunteer ☐ Other _____

DID THIS TAKE PLACE DURING:
☐ Practice ☐ Competition ☐ Club activity ☐ Pre-activity ☐ Sanctioned event ☐ During activity ☐ After activity ☐ While traveling

IF DURING EVENT, WHICH DISCIPLINE?
☐ Swim ☐ Run ☐ Bike ☐ Transition

INJURED PERSON INFORMATION:

Last	**First**	**Middle**	**Telephone Number ( )**	☐ **Single** ☐ **Married**
Address			**City**	**State** **Zip**
D.O.B:	☐ **Male** ☐ **Female**		**Employer and Address:**	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last	**First**	**Middle**	**Telephone Number ( )**
Address			**City** **State** **Zip**

INCIDENT LOCATION
- ☐ Competition area
- ☐ Parking lot
- ☐ Admission area
- ☐ Restrooms/locker rooms
- ☐ Off property
- ☐ Store area
- ☐ Bleachers/stands
- ☐ Premises/ground
- ☐ OTHER: _____

CLASSIFICATION
- ☐ Facility or event related
- ☐ Non-injury
- ☐ Not facility or event related
- ☐ Minor injury or illness
- ☐ Serious injury or illness

PRIMARY INJURY
- ☐ Abrasion
- ☐ Allergy
- ☐ Amputation
- ☐ Cold Injury
- ☐ Dislocation
- ☐ Drowning
- ☐ Electrical Shock
- ☐ Foreign Body
- ☐ Fracture
- ☐ Hypertension
- ☐ Laceration
- ☐ Seizure
- ☐ Strain/Sprain
- ☐ Contusion
- ☐ Heat Exhaustion
- ☐ Cardiac
- ☐ Stroke
- ☐ Pain
- ☐ Tooth/Mouth
- ☐ Illness
- ☐ Sting/Bite
- ☐ Nausea
- ☐ Concussion
- ☐ Burn
- ☐ Death

INCIDENT
- ☐ Assault/Sexual
- ☐ Slip, bodily reaction
- ☐ Assault/Non-Sexual
- ☐ Slip/Fall
- ☐ Fall (different level)
- ☐ Fall (same level)
- ☐ Collision (with object)
- ☐ Collision (participant/participant)
- ☐ Collision (participant/spectator)
- ☐ Collision (spectator/spectator)
- ☐ Caught in, on, between
- ☐ Struck by falling/flying object
- ☐ Auto/Property
- ☐ Animal/insect bite/sting
- ☐ Drug Testing
- ☐ Trip/Fall
- ☐ Overexertion
- ☐ Eligibility
- ☐ Aquatic

BODY PART INJURED
- ☐ Eye (L/R)
- ☐ Nose
- ☐ Neck
- ☐ Ear (L/R)
- ☐ Knee (L/R)
- ☐ Internal
- ☐ Shoulder (L/R)
- ☐ Elbow (L/R)
- ☐ Wrist (L/R)
- ☐ Torso
- ☐ Ankle (L/R)
- ☐ Arm (L/R)
- ☐ Back
- ☐ Tooth
- ☐ Face
- ☐ Head
- ☐ Hip (L/R)
- ☐ Foot (L/R)
- ☐ Hand (L/R)
- ☐ Leg (L/R)

MEDICAL SERVICES
- ☐ Antacid
- ☐ Aspirin
- ☐ Aspirin substitute
- ☐ Bandaged
- ☐ Ointment/antiseptic
- ☐ Rest
- ☐ Removal
- ☐ CPR
- ☐ Cleansed
- ☐ Other: _____
- ☐ Eye rinse
- ☐ Glucose
- ☐ Ice Pack
- ☐ Oxygen
- ☐ Splinted
- ☐ Wrapped
- ☐ Exam
- ☐ Cold Pack

Treated by _____

DISPOSITION
- ☐ Released to parent
- ☐ Refusal of care
- ☐ Refer to doctor
- ☐ Refer to hospital or clinic
- ☐ Medical attention
- ☐ EMS transport
- ☐ Patient requested EMS transport
- ☐ Released to personal vehicle
- ☐ Police
- ☐ Ambulance
- ☐ Report only

Describe how the incident occurred:

WITNESS INFORMATION:

NAME	ADDRESS	TELEPHONE NUMBER
1.		
2.		

Name of Race Director or Official or MD (no relationship to claimant) _____ (Print Name)

Name of Race Director or Official or MD (no relationship to claimant) _____ (Signature)