



INCIDENT REPORT



Welsh Pony & Cob Society of Australia Inc.

Site/Venue of accident:
Exact location overleaf....

Address:

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

Contact Person: **Date of Accident:**

Time of Accident: **Horse Name** own
 hired

Weather conditions:

Staff member(s) in charge of and/or supervising injured party: **Numbers under supervision:**

INJURED PERSON DETAILS:

Name:

Address:

Phone: **Date of Birth:** **Experience in riding**
Beginner/moderate/experienced

ACCIDENT OCCURRED WHILE:

- | | | |
|---|---|---|
| <input type="checkbox"/> Mounting | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Dismounting |
| <input type="checkbox"/> Unmounted Activity | <input type="checkbox"/> Jumping in Arena | <input type="checkbox"/> If other please detail |
| <input type="checkbox"/> Flat work/Dressage | <input type="checkbox"/> Trail Ride | |

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 | <input type="checkbox"/> 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 (please detail) | |



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WITNESS DETAILS:

Name:	<input type="text"/>		
Address:	<input type="text"/>		
Phone(s)	<input type="text"/>	Date of Birth:	<input type="text"/>
		<input type="checkbox"/> Staff member <input type="checkbox"/> Volunteer / Other rider <input type="checkbox"/> Other (specify)	

ACCIDENT SUMMARY

Description of accident, exact location, observations of signs and symptoms of injuries, treatment and follow up; include times and names of those involved in treatment at all stages.

Signed	<input type="text"/>	Date:	<input type="text"/>
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- Please find attached a signed waiver
- Please find attached supporting documentation