



Instructions/Guidance

PONY CLUB WHERE ACCIDENT/INCIDENT OCCURED:

Club Name:				
Address:				
Phone:		Fax No:		
Email:				
Contact Person:			Date of Accident:	

Time of Accident/Incident:			
Weather conditions:			
Person in Charge of Group:	Number under supervision:	Senior Official of the day:	

INJURED PERSON DETAILS (if applicable):

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

ACCIDENT ACTIVITY:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Mounting | <input type="checkbox"/> Dismounting | <input type="checkbox"/> Trail Ride |
| <input type="checkbox"/> Flat work Riding | <input type="checkbox"/> Jumping | <input type="checkbox"/> Cross Country |
| <input type="checkbox"/> Unmounted Activity | <input type="checkbox"/> Other | |

If other please detail in box

Risk Warning date signed:

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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"/> Other 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 | |

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WITNESS DETAILS:

Name:	<input type="text"/>		
Address:	<input type="text"/>		
Phone:	<input type="text"/>	Fax No:	<input type="text"/>
Email:	<input type="text"/>		

Name:	<input type="text"/>		
Address:	<input type="text"/>		
Phone:	<input type="text"/>	Fax No:	<input type="text"/>
Email:	<input type="text"/>		

Name:	<input type="text"/>		
Address:	<input type="text"/>		
Phone:	<input type="text"/>	Fax No:	<input type="text"/>
Email:	<input type="text"/>		

ACCIDENT/INCIDENT SUMMARY

ACTION TAKEN

Signed:	<input type="text"/>	Date:	<input type="text"/>
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This is not an official insurance Claim Form; any insurance claim must be made by the injured party.