United States Equestrian Federation, Inc.

Accident/Injury Report Form

4047 Iron Works Parkway, Lexington, KY 40511-8483 Phone: (859) 258-2472 Fax: (859) 231-6662 www.usef.org

This section is to be completed by the Steward/Technical Delegate who should note the circumstances as indicated on the form and also provide information regarding responders, EMS providers and facility transported to so that the medical records could be located if required.
(Please check where applicable.)

URGENT – Please check if: ❑ FATALITY ❑ SERIOUS INJURY – Contact USEF immediately – Weekend Emergency Number is: 1 (859) 312-5186. (If a serious accident occurs at an Eventing Competition, please also contact USEA.)

1. Injured Person/Horse _____ Date/Time of Incident: _____

2. Competition: _____ Competition USEF #: _____

City: _____ State: _____

3. ❑ Junior ❑ Senior Sex of Person: ❑ M ❑ F Sex of Horse: ❑ M ❑ G ❑ S ❑ C ❑ F

4. Category of Participation: ❑ Rider ❑ Handler ❑ Groom ❑ Spectator ❑ Official ❑ Visitor
❑ Volunteer ❑ Ring/Jump Crew ❑ Other _____

5. Location on grounds where injury occurred: ❑ Cross Country Course ❑ Show Ring ❑ Dressage ❑ Warm-up Ring
❑ Stabling ❑ Parking ❑ Other _____

6. Name and type of class **(must complete if accident happened during or in preparation for a class)**:

_____

7. If over fences, specify the **type of jump** and **height (must complete if applicable)**: _____

_____

8. **Fence:** Safety cups? ❑ Yes ❑ No ❑ N/A Frangible (cross-country) ❑ Yes ❑ No ❑ N/A

9. Describe what happened: _____

_____

_____

_____

_____

10. Witnesses of incident, if any:

Name: _____ PH: _____

Name: _____ PH: _____

Name: _____ PH: _____

11. Protective Equipment Worn: ASTM/SEI Helmet: ❑ Yes ❑ No Unapproved Helmet: ❑ Yes ❑ No
Chest Protector: ❑ Yes ❑ No ❑ N/A ❑ Other: _____

12. Other Contributing Factors (e.g. Footing/Weather/Loose Dog/Golf Cart, etc.): _____

_____

_____

_____

This section completed by: _____ Date: _____

Please complete second page

Copy to: (white) USEF (yellow) Organizer/Manager (green) Steward/TD

This section to be completed by the Steward/TD, or medical personnel or veterinarian who treated the patient.

13. Injured Person/Horse: _____ Date: _____

14. Nature of Injury/Narrative: _____

_____

_____

_____

_____

_____

15. Treatment: ❑ Onsite ❑ Transported (Ambulance) ❑ Transported (other) ❑ None
❑ Refused Transport ❑ Refused Treatment ❑ Other _____

16. By whom: ❑ EMT ❑ Paramedic ❑ Physician trained in pre-hospital trauma care ❑ Spectator
❑ Nurse trained in pre-hospital trauma care ❑ Veterinarian ❑ Official ❑ Other _____

17. Describe treatment: _____

_____

_____

_____

_____

18. Possible Concussion/Head Injury: ❑ Yes ❑ No

19. Possible Broken Bones: ❑ Yes ❑ No

20. Name of On-site treating EMS personnel/veterinarian: _____

21. Address: _____ PH: _____

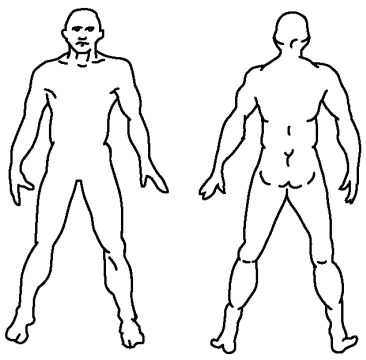
22. Name of EMS Provider(s) (Ambulance, Helicopter, etc.): _____

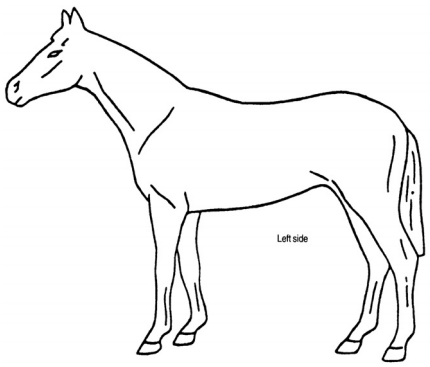
23. Address: _____ PH: _____

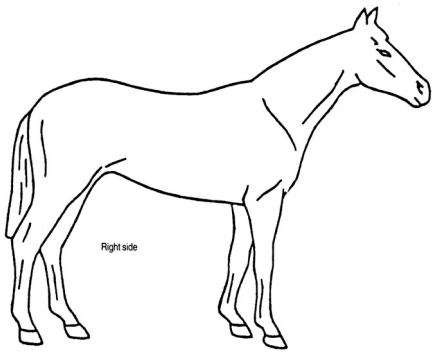
24. Facility patient transported to: _____ PH: _____

25. Address: _____

26. Please circle all injured area(s) on the models below.
Parts of body affected: _____







This section completed by: _____ Date: _____
Signature

IMPORTANT – Did you:
Indicate if a fatality occurred? ❑ Yes ❑ No
Answer all the questions? ❑ Yes ❑ No
Obtain eyewitness reports? ❑ Yes ❑ No ❑ N/A
Sign the form? ❑ Yes ❑ No