

Mosaic Outdoor Mountain Club INCIDENT/INJURY/ACCIDENT REPORT FORM

The primary purpose of this report is to aid in the prevention of accidents. The person filling out the form should be familiar with the circumstances of the accident, and therefore, the person(s) directly involved should complete it. Please describe any unusual incidents which could have been a threat to the safety and well-being of one participant or to the whole group. Such incidents could be injuries, medical problems, and hypothermia, getting lost, participant conflicts, group separation or other potentially dangerous encounters.

1. Report completed by (name, address and phone number) _____

2. Date of incident _____

3. Location _____

4. Names and phone numbers of person(s) directly involved

5. If Injured was taken to Hospital or Attended to by Ranger / Police / EMT Please list as much info on these people and/or services to able to contact them for their reports.

6. Details of the accident (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall/slip on rock | <input type="checkbox"/> Failed to follow route | <input type="checkbox"/> Equipment failure |
| <input type="checkbox"/> Fall/slip on snow/ice | <input type="checkbox"/> Lightning | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Falling rock or object | <input type="checkbox"/> Exhaustion | _____ |
| <input type="checkbox"/> Exceeded abilities | <input type="checkbox"/> Party separated | _____ |
| <input type="checkbox"/> Avalanche | <input type="checkbox"/> Weather | |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Darkness | |

7. Type of injury or illness (check all that apply)

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Infection | <input type="checkbox"/> Preexisting condition |
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Psychological | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Laceration | <input type="checkbox"/> Frostbite | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Hypothermia | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Strain | <input type="checkbox"/> Heat stroke | _____ |
| <input type="checkbox"/> Sprain | | _____ |

8. Narrative description of accident (use extra sheet if needed):

9. Additional information (use extra sheets if necessary):