



2020 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?
USAT MEMBERSHIP STATUS:
INJURED PERSON:
DID THIS TAKE PLACE DURING:
IF DURING EVENT, WHICH DISCIPLINE?

INJURED PERSON INFORMATION:

Last First Middle Telephone Number
Address City State Zip
D.O.B: Employer and Address:

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last First Middle Telephone Number
Address City State Zip

INCIDENT LOCATION
CLASSIFICATION
PRIMARY INJURY
INCIDENT
BODY PART INJURED
MEDICAL SERVICES
DISPOSITION

Describe how the incident occurred:

WITNESS INFORMATION:

Table with 3 columns: NAME, ADDRESS, TELEPHONE NUMBER. Rows 1 and 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)