ACCIDENT REPORT FORM

Name of person who treated casualty and is completing PART A of this form

* delete as appropriate

1. ABOUT THE PERSON WHO HAD THE ACCIDENT Male ☐ Female ☐ **PART A**

Gymnast ☐ Member Of Public ☐ Coach ☐ Other ☐

Forename	Mobile Tel No.
Surname	Home Tel No.
Address	Work Tel No.
Postcode	Date of Birth

2. ABOUT THE ACCIDENT – (ADDITIONAL SHEETS MAY BE USED – PLEASE ATTACH IF NECESSARY)

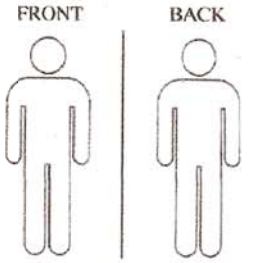
Date | TIME * AM/PM | Precise Location

What Happened?

This information is provided by;
☐ Casualty
☐ Another person;
- NAME

3. TREATMENT GIVEN / TYPE OF INJURY

First Aid treatment given:	Indicate position & type of injury:
Name of First Aider:	



MARK LOCATION ON BODY

IF MEMBER OF PUBLIC: Taken to hospital directly from site by any method: YES ☐ NO ☐

In hospital for 24 hours or more: YES ☐ NO ☐ Off work for more than 3 days: YES ☐ NO ☐

4. WITNESSES

1. Name:	Address:
Home Tel No.	Work Tel No.
2. Name:	Address:
Home Tel No.	Work Tel No.

ACTION TAKEN TO PREVENT A RECURRENCE **PART B**

Additional Sheets Attached Y ☐ ☐	Incident Report Completed Y ☐ ☐	Form No:
Signed:	PRINT:	Date: