



2024 EVENTING HUMAN ACCIDENT/INJURY REPORT FORM

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

URGENT - IN CASE OF FATALITY OR SERIOUS INJURY CONTACT USEF IMMEDIATELY AND INCLUDE A COPY OF THE ENTRY FORM WITH REPORT! WEEKEND EMERGENCY NUMBER IS 859.312.5186.

Please check if: FATALITY SERIOUS INJURY APPARENT CONCUSSION OR LOSS OF CONSCIOUSNESS *Submit report within 24 hours of the incident.*

Please also contact Rob Burk at 571.340.1553 (cell) as soon as possible and fax a copy of the report to USEA headquarters within 24 hours. USEA fax: 703.779.0550 (Eventing Only).

OTHER INJURY

INCIDENT DESCRIPTION

1. Competition Name: _____ USEF Competition #: _____

Accident Date: _____ Time: _____ AM PM Age: Junior Senior Sex of Person: F M

Person's Name: _____ USEF Membership #: _____

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

Emergency Contact Name: _____ Relationship: _____ Phone#: _____

2. Horse's Name (if involved in incident): _____ USEF Membership #: _____

Age: _____ Sex: Mare Gelding Stallion Colt Filly

3. Location where incident occurred: Cross-Country Course Show Jumping Dressage Warm-up Ring Stabling Parking Other: _____

4. Level and division (must complete if accident happened during or in preparation for a class): _____

5. If fence-related fences (must complete if applicable) specify: type of JUMP _____ and HEIGHT _____

6. Fence Safety Features: Safety cups? Yes No N/A Frangible (cross-country) Yes No N/A Rotational Fall: Yes No N/A

7. Ring Location: Indoor Outdoor Covered

Footing: Sand Dirt Grass Artificial Natural Other: _____

Footing Condition: Deep Heavy Slippery Good Firm Hard Rough/Rugged Other: _____

Weather: Sunny Cloudy Raining Windy Foggy Snowing Extreme Temp. Artificial Light

8. Protective Equipment Worn: ASTM/SEI Helmet: Yes No Unapproved Helmet: Yes No

Body Protecting Vest: Yes No N/A Inflatable Vest: Yes No N/A Other: _____

9. Describe nature of incident/narrative: _____

10. Name of witness (other than TD): _____ Phone #: _____

This section completed by: _____ Date: _____

TREATMENT INFORMATION

This section to be completed by the Technical Delegate, or medical personnel who treated the patient.

11. Treatment: On-site Transported (Ambulance) Transported (other) None Refused Transport Refused Treatment

12. Treated by: EMT/ Paramedic Physician trained in pre-hospital trauma care Nurse trained in pre-hospital trauma care Spectator Official

Other: _____

13. Describe treatment: _____

Person's Name: _____ Date: _____

MANDATORY SUSPENSION

14. **Apparent Concussion or Loss of Consciousness:** Yes No If yes:
- No loss of consciousness and no sign of concussion = No mandatory suspension
 - No loss of consciousness but with brief symptoms of concussion (e.g. confusion, loss of memory, altered mental state) which resolve within 15 minutes (both at rest and exercise) = Minimum 7 day mandatory suspension
 - Any loss of consciousness, however brief, or symptoms of concussion persisting after 15 minutes = Minimum 21 day mandatory suspension

This section must be completed and signed by the qualified medical personnel to document the mandatory suspension period.

Name of on-site qualified medical personnel: _____

Certification/License #: _____ Issuing Body (e.g. State): _____ Contact Phone #: _____

NOTE:

- All mandatory suspension periods count the day of injury as the first day of the suspension period.
- Upon the expiration of the mandatory suspension period, the competitor may return to competition by submitting a medical release note as required by GR848.6.

Any competitor who has established a baseline cognitive skills level (e.g. ImPact Test) may return to competition upon submission to the Federation confirmation that they have passed an exam establishing that they have suffered no impairment of that level, in addition to the medical release as required in GR848.6.

OTHER INJURY/INCIDENT INFORMATION

For any competitor with suspected head injury/apparent concussion, serious injury, broken bones, or that is transported from the grounds via ambulance, please submit their Entry Blank with this report to the Federation.

15. Suspected type of injury/incident: None Fractures and Bone Stress Joint (Non-Bone) and Ligament Muscle and Tendon Contusions
- Lacerations and Skin Lesions Medical Condition: _____ Other: _____
16. Location of Injury: _____
17. Name of On-site treating EMS personnel (if applicable): _____ Phone #: _____
18. Name of EMS Provider(s) (Ambulance, Helicopter, etc.): _____ Phone #: _____
19. Facility patient transported to: _____ Phone #: _____

ADDITIONAL MATERIALS

- Did you obtain eyewitness reports? Yes (*please attach*) No
- Include clearance to return to competition, if applicable? Yes (*please attach*) No N/A
- Did you call report in to USEF? Yes No N/A
- If yes, date and time called in: _____ To whom: _____
- Technical Delegate's name: _____ USEF Number: _____
- Technical Delegate's signature: _____ Date: _____
- Did the TD witness the incident? Yes No
- Safety Officer/Coordinator's name: _____ Phone Number: _____
- Safety Officer/Coordinator's signature: _____ Date: _____