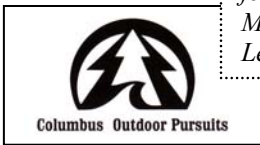


Incident Report Form

This form should be promptly completed for each accident and returned to the Risk Management Committee and Activity Leader within 7 days after the trip

Trip Name _____
 Date _____ Time _____ am/pm
 Location of Incident _____



Identification of Injured

Name _____ COP Membership # _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Email _____ @ _____
Responsible person to contact _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Email _____ @ _____

Witnesses:

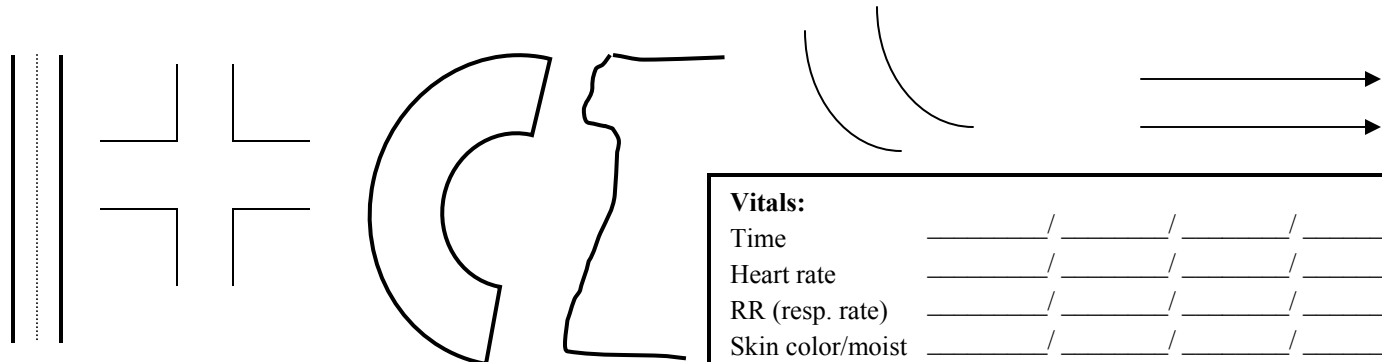
(Statements by witnesses should be taken on separate sheets and attached)

Name _____ Phone _____ Email _____ @ _____
 Address _____ City _____ State _____ Zip _____

Name _____ Phone _____ Email _____ @ _____
 Address _____ City _____ State _____ Zip _____

Description of incident (include exact location, name of river/trail/road/nearest rapid/intersections/address) position of witnesses and injured, relevant conditions (trail/road conditions, river level, weather etc.)

Attach sketch:



Vitals:

Time _____ / _____ / _____ / _____
 Heart rate _____ / _____ / _____ / _____
 RR (resp. rate) _____ / _____ / _____ / _____
 Skin color/moist _____ / _____ / _____ / _____
 AVPU* _____ / _____ / _____ / _____
 *(level of responsiveness Alert, Verbal, Pain, Unresp.)

- | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Left | <input type="checkbox"/> Foot | <input type="checkbox"/> Neck | <input type="checkbox"/> Eye |
| <input type="checkbox"/> Right | <input type="checkbox"/> Ankle | <input type="checkbox"/> Thumb | <input type="checkbox"/> Face |
| <input type="checkbox"/> Both | <input type="checkbox"/> Lower leg | <input type="checkbox"/> Hand | <input type="checkbox"/> Head |
| | <input type="checkbox"/> Knee | <input type="checkbox"/> Wrist | <input type="checkbox"/> Teeth |
| | <input type="checkbox"/> Hip | <input type="checkbox"/> Arm | <input type="checkbox"/> Multiple |
| | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Chest | <input type="checkbox"/> Mouth | |
| | <input type="checkbox"/> Back | <input type="checkbox"/> Nose | |

OVER



Front



Back

Emergency Response:

Was participant evacuated? _____ Yes _____ No
Where to: _____
How? _____ car _____ EMS _____ Helicopter _____ Self
If evacuated, how notified?
_____ Phone _____ 2-way radio _____ Other
Acute care was administered by
_____ Physician _____ Nurse _____ EMT _____ Other (identify)
Was CPR performed? _____ Yes _____ No

Contributing Factors:

Equipment (choice, failure) _____
Pre-existing condition of injured (asthma, fatigue, Hypothermia) _____

Group Size: _____
Rescue Attempt: _____

Conditions When Incident Occurred:

Weather

- Clear
- Rain
- Fog
- Warm
- Cold
- Snowing

Wind

- Light
- Moderate
- Strong

Visibility

- Good
- Fair
- Poor

Trail/Road

- Dry
- Damp/wet
- Muddy
- Icy
- Smooth
- Rough
- Gravel
- Other
- Steep Downhill
- Gradual Downhill
- Gradual Uphill
- Steep Uphill
- Railroad Crossing
- Sharp Turn
- Snow covered (depth) _____
- Stream (depth) _____
- Approx Altitude _____ (If above 5000 ft)

River

Rapid Classification _____

Level

- High
- Moderate
- Low

Accident Type

- Vertical Pin
- End Pin
- Bottom Splat
- Recirculation
- Long Swim
- Foot Entrapment

Disposition

Describe emergency care administered: _____

Describe incident in patients own words: (put in quotes) _____

If an injured person refuses treatment, ask him/her to complete and sign the following:
I (print name), _____, by my own free will have refused the first aid and subsequent treatment offered to me at the time of my accident while participating in this COP trip. Employees, volunteers and The Columbus Outdoor Pursuits did not render me treatment in accordance with my wishes and I will not subsequently hold them responsible in any way for not doing so.
Signature _____ Date ____/____/____

Rescuers Comments: _____

This form completed by _____ Date _____
Address _____ City _____ State _____ Zip _____
Phone _____ email _____@_____
Signature _____

If additional information is needed, PLEASE attach additional sheets of paper!