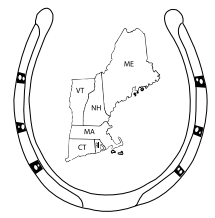


New England Horsemen's Council, Inc.

28 Oak Hill Drive
Hampstead, NH 03841



ACCIDENT/INCIDENT REPORT

This section is to be complete by Steward / TD / Manager / EMT (Please circle where applicable)

Competition: _____ City: _____ State: _____

Date: _____

Injured Person/Horse Name: _____ Phone: _____

Age: _____ Sex of Person/Horse: M F M G S Date and Time: _____

Category of Participation: Rider (Entry ID# _____), Groom _____, Spectator _____,
Official _____, Volunteer _____, Ring/Jump Crew _____, Visitor _____, Other: _____

Location on grounds where injury occurred: Parking _____, Stabling _____, Show Ring _____,
Warm-up Ring _____, Cross Country Course _____, Other: _____

Class /Division in which injury occurred: _____

If over fences, specify the type of jump and height: _____

Was the fence equipped with safety cups? Yes _____ No _____

Incident Description (Describe what happened): _____

Were you a witness to the incident? Yes _____ No _____

If not, who reported this to you? Name: _____ Phone: _____

Alleged cause of Injury (Describe how the incident occurred): _____

Protective equipment worn: Helmet (ASTM/SEI) Yes _____ No _____ Chest Guard: Yes _____ No _____

Other: _____

Other Relative Circumstances (e.g. Footing/Weather/ Loose Dog): _____

This section completed by: _____ Date: _____

Please complete other side of form

**This section is to be complete by EMT / Paramedic / Doctor trained
in pre-hospital trauma care / Veterinarian**

Competition: _____ **City:** _____ **State:** _____

Injured Person/Horse Name: _____ Date and Time: _____

Nature of Injury/Narrative:

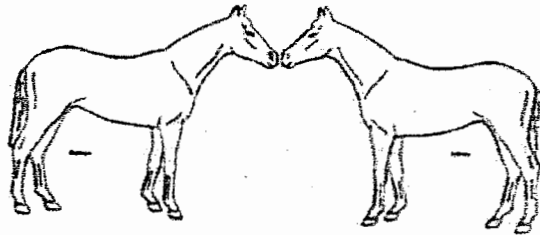
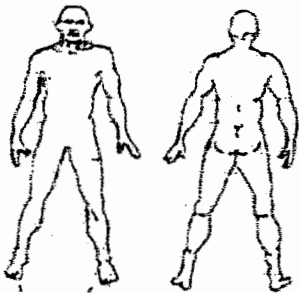
Treatment: Onsite _____ Transported _____ None _____ Refused _____

By whom: EMT/Paramedic _____ MD _____ Spectator _____ Official _____ Other _____

List name of anyone who treated the injury: _____

Describe Treatment: _____

Parts of Body Affected: _____



Please circle all injured area(s) on the models above

If you wish to provide additional information, please use space below.

This section completed by: _____ **Date:** _____

Medical Professional (Please Print Name)