

**Sierra Foothills Cycling Club**  
**FIRST REPORT OF BODILY INJURY/AUTO ACCIDENT/PROPERTY DAMAGE**

Mail completed form to: SFCC, Attn: Ride Leader, PO Box 3124, Auburn, CA 95604

DATE OF INCIDENT _____	TIME OF INCIDENT _____ AM/PM
DOES THE INJURED PERSON HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please provide company name and policy number _____	
INJURED PERSON: <input type="checkbox"/> Club Member <input type="checkbox"/> Non-member <input type="checkbox"/> Participant <input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____	
Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
The injured person was riding: <input type="checkbox"/> Tandem bike <input type="checkbox"/> Single bike	
INCIDENT TOOK PLACE DURING: <input type="checkbox"/> Club Ride <input type="checkbox"/> Special Event <input type="checkbox"/> Time Trial <input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event <input type="checkbox"/> Fundraiser	
If during a special event, list name and sponsor of event: _____	

**INJURED PERSON INFORMATION**

Last Name	First	Middle	Telephone No. (    )	<input type="checkbox"/> Single	<input type="checkbox"/> Married
Address			Social Security Number		
City	State	Zip	Employer Name and Address		
Age	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female			

**GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)**

Last Name	First	Middle	Telephone No. (    )
Address		City	State    Zip

**SUSPECTED PRE-EXISTING CONDITION:**     YES     NO

<p><b>INCIDENT LOCATION</b></p> <input type="checkbox"/> Off-road <input type="checkbox"/> City street <input type="checkbox"/> Parking lot <input type="checkbox"/> Highway <input type="checkbox"/> Registration area <input type="checkbox"/> Rural road <input type="checkbox"/> Restroom/locker room <input type="checkbox"/> Off property <input type="checkbox"/> Premises/grounds <input type="checkbox"/> Rest stop	<p><b>INCIDENT</b></p> <input type="checkbox"/> Assault/sexual <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Assault/non-sexual <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Overexertion <input type="checkbox"/> Chased by dog <input type="checkbox"/> Eligibility <input type="checkbox"/> Bite by dog <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Collision (with parked car) <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Collision (with moving car) <input type="checkbox"/> Trip/fall <input type="checkbox"/> Collision (with object/animal) <input type="checkbox"/> Slip/fall <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Auto/property (also complete reverse side)
<p><b>RIDER ACTIVITY</b></p> <input type="checkbox"/> Being passed <input type="checkbox"/> Turning right <input type="checkbox"/> Turning left <input type="checkbox"/> Straight <input type="checkbox"/> Passing <input type="checkbox"/> Intersection	<p><b>ILLNESS/INJURY CLASSIFICATION</b>    <input type="checkbox"/> Minor    <input type="checkbox"/> Serious    <input type="checkbox"/> None</p>
<p><b>PRIMARY INJURY</b></p> <input type="checkbox"/> Allergy <input type="checkbox"/> Burn <input type="checkbox"/> Illness <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Cold injury <input type="checkbox"/> Nausea <input type="checkbox"/> Fracture <input type="checkbox"/> Contusion <input type="checkbox"/> Amputation <input type="checkbox"/> Death <input type="checkbox"/> Sting/bite <input type="checkbox"/> Electrical shock <input type="checkbox"/> Drowning <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Heat exhaustion <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasion <input type="checkbox"/> Pain <input type="checkbox"/> Strain/sprain <input type="checkbox"/> Foreign body <input type="checkbox"/> Hypertension <input type="checkbox"/> Tooth/mouth <input type="checkbox"/> <input type="checkbox"/> Cardiac	<p><b>BODY PART INJURED</b></p> <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Torso <input type="checkbox"/> Finger or Toe <input type="checkbox"/> Tooth <input type="checkbox"/> Back <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Face <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Head <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Neck <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Foot (L/R)
<p><b>WEATHER CONDITIONS</b></p> <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy <p><b>ROAD CONDITIONS</b></p> <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy <p><b>ROAD TYPE</b></p> <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel	<p><b>DISPOSITION</b></p> <input type="checkbox"/> Ambulance <input type="checkbox"/> Refer to hospital/clinic <input type="checkbox"/> Police <input type="checkbox"/> Medical attention <input type="checkbox"/> Refusal of care <input type="checkbox"/> Released to parent <input type="checkbox"/> Report only <input type="checkbox"/> EMS transport <input type="checkbox"/> Continued riding <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Released to personal vehicle

Describe how the incident occurred:

**WITNESS INFORMATION**

Name	Address	Telephone Number
1.		(    )
2.		(    )

Signature of Ride Leader or Official (with no relationship to claimant) \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

## FIRST REPORT OF AUTO ACCIDENT OR PROPERTY DAMAGE

If the injury or property damage was the result of an auto accident, please complete this section.

PERSON DRIVING THE AUTO: \_\_\_\_\_  Injured  Not injured

Address: \_\_\_\_\_

OWNER OF THE AUTO: \_\_\_\_\_

Address: \_\_\_\_\_

AUTO MAKE/MODEL/YEAR: \_\_\_\_\_

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN THE AUTO:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Injured  Not injured

Injured  Not injured

NOTE: PLEASE USE THE REVERSE SIDE OF THIS FORM TO SUPPLY INJURY INFORMATION. A LIST OF ALL PASSENGERS AND INJURY INFORMATION FOR ALL INJURED PERSONS SHOULD BE SUPPLIED. PLEASE USE ADDITIONAL INCIDENT REPORT FORMS OR SEPARATE SHEETS OF PAPER, IF NECESSARY.

PURPOSE OF TRIP: \_\_\_\_\_

NAME OF POLICE DEPARTMENT WHICH INVESTIGATED THE ACCIDENT: \_\_\_\_\_

**If the accident involved a collision with another automobile, please also complete the following:**

PERSON DRIVING OTHER AUTO: \_\_\_\_\_  Injured  Not injured

Address: \_\_\_\_\_

OWNER OF OTHER AUTO: \_\_\_\_\_

Address: \_\_\_\_\_

OTHER AUTO MAKE/MODEL/YEAR: \_\_\_\_\_

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN OTHER AUTO:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Injured  Not injured

Injured  Not injured

(Attach separate sheet of paper, if necessary.)

### PROPERTY DAMAGE (OTHER THAN AUTO ACCIDENTS)

If property was damaged, please supply a description of the property and list the owner. (If an auto accident, see reverse side.)

Description of property: \_\_\_\_\_

Description of damage: \_\_\_\_\_

Owner's name and address: \_\_\_\_\_

Owner's telephone numbers: (\_\_\_\_\_) \_\_\_\_\_ (day) (\_\_\_\_\_) \_\_\_\_\_ (evening)