

CYCLING AUSTRALIA ACCIDENT REPORT FORM

we are cycling... start to finish...



THIS FORM MUST BE FAXED, EMAILED OR POSTED TO CYCLING AUSTRALIA

OFFICE USE ONLY

Received

Processed

WITHIN TEN WORKING DAYS OF ACCIDENT.

Postal: PO Box 6310, Alexandria NSW 2015

Fax: 02 9339 5888

Email: membership@cycling.org.au

Injury record books should be kept at each club, with or near the first aid kit. All injuries and treatments should be recorded, outlining the nature of the injury, treatment administered and any follow up action. Insurance claims have to be lodged within 12 months of the accident and records may be requested. Therefore it is essential that all records are kept up to date and this form be forwarded to Cycling Australia.

Event / Location of Incident

DETAILS OF INJURED PERSON

Employee Member of Public Club Member Other _____

Licence Number	Date of Birth	
First Name	Surname	
Postal Address		
Suburb	State	Post Code
Home Phone	Mobile	
Email	Gender	M <input type="checkbox"/> F <input type="checkbox"/>
Has the parent / guardian / emergency contact of the injured person been notified of the accident?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Trade Team		
Emergency Contact Person	Phone	Relationship
Details of injury (part of body / suspected injury)		
First Aid Management		
Signature of Injured Person / Parent / Guardian / Emergency Contact		Date

PERSONAL DETAILS OF PERSON SUBMITTING FORM

First Name	Surname
Home Phone	Mobile
Date of Incident	Time of Incident
Signature	Date
Description of Incident	

FOLLOW UP REPORT

TYPE OF CYCLING

- | | | | | |
|---------------------|--------------------------|-----------------------|--------------------------|----------------------|
| Official Club Event | <input type="checkbox"/> | CA/State racing event | <input type="checkbox"/> | Please specify _____ |
| Training | <input type="checkbox"/> | Other Racing Event | <input type="checkbox"/> | Please specify _____ |
| Commuting | <input type="checkbox"/> | | | |
| Recreational | <input type="checkbox"/> | Other | <input type="checkbox"/> | Please specify _____ |

LOCATION OF INCIDENT

- | | | | | |
|--------------------|--------------------------|---------------------|--------------------------|----------------------|
| Velodrome Track | <input type="checkbox"/> | Unsealed Road | <input type="checkbox"/> | |
| Velodrome In-field | <input type="checkbox"/> | Official Cycle Path | <input type="checkbox"/> | |
| Velodrome Grounds | <input type="checkbox"/> | Mountain Bike Trail | <input type="checkbox"/> | |
| Sealed Road | <input type="checkbox"/> | Other | <input type="checkbox"/> | Please specify _____ |

TYPE OF INCIDENT

- | | | | | |
|--------------------|--------------------------|-------------------|--------------------------|----------------------|
| Trip / Fall / Slip | <input type="checkbox"/> | Bicycle Collision | <input type="checkbox"/> | |
| Lacerations | <input type="checkbox"/> | Vehicle Collision | <input type="checkbox"/> | |
| Overheating | <input type="checkbox"/> | Other | <input type="checkbox"/> | Please specify _____ |
| Dehydration | <input type="checkbox"/> | | | |

PART OF BODY INJURED

- | | | | | | |
|-------|--------------------------|-------------|--------------------------|----------------------|--------------------------|
| Head | <input type="checkbox"/> | Hip / Leg | <input type="checkbox"/> | Arm / Shoulder | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | Mouth | <input type="checkbox"/> | Hip / Leg | <input type="checkbox"/> |
| Eyes | <input type="checkbox"/> | Feet / Toes | <input type="checkbox"/> | Hip / Leg | <input type="checkbox"/> |
| Ankle | <input type="checkbox"/> | Knee | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| | | | | Please specify _____ | |

NATURE OF SUSPECTED INJURY

- | | | | | | |
|-----------------|--------------------------|--------------|--------------------------|----------------------|--------------------------|
| Sprain / Strain | <input type="checkbox"/> | Dislocation | <input type="checkbox"/> | Concussion | <input type="checkbox"/> |
| Puncture | <input type="checkbox"/> | Bruising | <input type="checkbox"/> | Foreign Body | <input type="checkbox"/> |
| Graze | <input type="checkbox"/> | Sting / Bite | <input type="checkbox"/> | Chipped Tooth | <input type="checkbox"/> |
| Infection | <input type="checkbox"/> | Fracture | <input type="checkbox"/> | No apparent injury | <input type="checkbox"/> |
| Burn | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| | | | | Please specify _____ | |

ACTION TAKEN

- | | | | | | |
|------------|--------------------------|----------------|--------------------------|----------------------|--------------------------|
| D.R.A.B.C. | <input type="checkbox"/> | Observation | <input type="checkbox"/> | Doctor at scene | <input type="checkbox"/> |
| R.I.C.E.R. | <input type="checkbox"/> | Hospital (car) | <input type="checkbox"/> | Hospital (ambulance) | <input type="checkbox"/> |
| Bandaging | <input type="checkbox"/> | Immobilisation | <input type="checkbox"/> | No action taken | <input type="checkbox"/> |
| Dressing | <input type="checkbox"/> | | | Other | <input type="checkbox"/> |
| | | | | Please specify _____ | |

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Signature of Cycling Australia Staff Member

Date