

USA CYCLING - FIRST REPORT OF OCCURRENCE

Event Name: _____ Permit #: _____

Event Organizer's Name: _____

Promoting Club(s): _____

Event Date(s): _____ Incident Date: _____

Number of Riders: _____ Number of Staff: _____ Number of Officials: _____

In Case of Serious Accident or Injury Contact USA Cycling

Injured Person's Role: Participant Volunteer Spectator Official Pedestrian Other: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Gender: Female Male X

Age: _____ DOB: _____ USAC Category: _____ USAC Member#: _____

Was the injured person wearing a helmet as the time of the incident: Yes No

Was the injured person riding: Single Bike Tandem Handcycle

Waiver and Release signed? Yes No *(Please ensure any waivers are submitted to USA Cycling.)*

Membership Type: Annual Member One-Day Non-Member

Incident occurred: Before Event During Event After Event Practice Set-up Travel

Type of Event:

Road Racing: <input type="radio"/> Criterium <input type="radio"/> Time Trial <input type="radio"/> Centerline RR <input type="radio"/> Closed RR <input type="radio"/> Other: _____	Mountain: <input type="radio"/> Cross Country <input type="radio"/> Downhill <input type="radio"/> Enduro <input type="radio"/> Dual Slalom <input type="radio"/> Other: _____	Ride: <input type="radio"/> Cyclocross <input type="radio"/> BMX Race <input type="radio"/> BMX Freestyle <input type="radio"/> Track <input type="radio"/> Other: _____	<input type="radio"/> Gran Fondo <input type="radio"/> Gravel <input type="radio"/> Fun Ride <input type="radio"/> Camp/Clinic <input type="radio"/> Other: _____	Weather: <input type="radio"/> Sunny <input type="radio"/> Raining <input type="radio"/> Foggy <input type="radio"/> Snowy <input type="radio"/> Extreme Temps <input type="radio"/> Other: _____	Road Conditions: <input type="radio"/> Wet <input type="radio"/> Dry <input type="radio"/> Ice Other: _____ Course Type: <input type="radio"/> Paved <input type="radio"/> Dirt <input type="radio"/> Gravel <input type="radio"/> Trail <input type="radio"/> Other: _____
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Incident Location:

- Off-Road
- Highway
- Parking Lot
- Rural Road
- City Street
- Off Premises
- Premises/Grounds
- Registration Area
- Restroom/Locker Area
- Velodrome/Track

Activity:

- Turning Right
- Turning Left
- Going Straight
- Being Passed
- Passing
- Intersection
- Stationary

Cause:

- Assault
- Struck - object
- Fall (different elevation)
- Collision - parked car
- Fall (same elevation)
- Collision - moving car
- Overexertion
- Collision - animal
- Equipment Failure
- Collision - participant/participant
- Animal Involvement
- Collision - participant/spectator
- Auto/Property (please complete next page)

Injury Type:

- Non-injury
- Minor injury/illness
- Major injury/illness

Body Part Injured:

- Eye Hand Wrist Foot Head Mouth Torso Back Internal
- Ankle Arm Shoulder Leg Face Neck Tooth Nose Finger/Toe
- Knee Hip Elbow Ear Other: _____

Primary Injury:

- Allergy/Sting Abrasion Nausea Burn Electrical Shock Dislocation Pain Amputation
- Concussion Cold Injury Tooth/Mouth Seizures Foreign Body Strain/Sprain Cardiac Stroke
- Heat Exhaustion Fracture Hypertension Drowning Laceration Death Other: _____

Disposition:

- Report Only Medical Attention Transport by Ambulance Released to Parent Released from Care
- Police Report Continued Riding Hospital Self Transport Refer to Hospital/Doctor Refusal of Care

Describe how the incident occurred:

Name of Chief Referee/Official/Reporter: _____ Date: _____

Phone: _____ e-mail: _____

Witness (with no relation to claimant) Name: _____

Phone: _____ e-mail: _____

USA CYCLING
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: Yes No

Driver Address: _____

Driver Phone: _____ Driver e-mail: _____

Owner of the Auto: _____

Owner Address: _____

Owner Phone: _____ Owner e-mail: _____

Vehicle Make: _____ Vehicle Model: _____ Vehicle Year: _____

List Name and Address of Passengers:

Passenger Name: _____ Injured: Yes No

Address: _____

Passenger Name: _____ Injured: Yes No

Address: _____

Use additional forms if you need to list more passengers.

Purpose of Trip: _____

Name of Agency Investigating Accident: _____

If the accident involved a collision with another vehicle, please complete the following:

Person Driving other Vehicle: _____ Injured: Yes No

Address of Driver: _____

Owner of Other Vehicle: _____

Address of Owner: _____

Vehicle Make: _____ Vehicle Model: _____ Vehicle Year: _____

List Name and Address of Passengers:

Passenger Name: _____ Injured: Yes No

Address: _____

Passenger Name: _____ Injured: Yes No

Address: _____

Use additional forms if you need to list more passengers.

PROPERTY DAMAGE
(OTHER THAN VEHICLE ACCIDENTS)

Description of Property: _____

Description of Damage: _____

Owner's Name: _____

Owner's Address: _____

Owner's Phone: _____ Owner's e-mail: _____

WITNESS INFORMATION

Witness Name: _____ Address: _____

Witness Name: _____ Address: _____