

AUSTRALIAN FLYBALL ASSOCIATION INC. INCIDENT REPORT FORM

Judge Competition Date

Host Club

Competitors Details:

Name Contact No.

CRN Dogs Name

Type of Incident
.....

AFA Rep. Advised Yes/No Host Club advised Yes/No

Particulars of Incident

Time Division Race No. Heat No.....

Human Injury Yes/No Dog Injury Yes/No
(If Human or Dog Injury please complete additional Injury Form)

Description of Incident
.....
.....
.....
.....
.....

Witnesses to Incident

Name Signature Stat. Dec. Yes/No

Address Contact No.

Name Signature Stat Dec. Yes/No

Address Contact No.

Action Taken

Judges Signature..... Date

(This report form must be forwarded to AFA Secretary within 48 hours of Incident or handed to the AFA Representative on the day of the Incident)

(One Incident form per dog per competition for Interference Only – either one, two or three offences)

Particulars of Human Injury

Name:			
Age	Sex:	Mem#:	
Nature of injury: <input type="checkbox"/> Sprains/Strains <input type="checkbox"/> Contusion (Bruise) <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasion/Open wound <input type="checkbox"/> Amputation <input type="checkbox"/> Fracture <input type="checkbox"/> Dislocations <input type="checkbox"/> Burns/scold <input type="checkbox"/> Exposure to elements <input type="checkbox"/> Psychological disorder/Stress <input type="checkbox"/> Object in eye <input type="checkbox"/> Other,.....			
Part/s of body injured	Side of Body	Region	Internal or External Injury
<input type="checkbox"/> Head	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Internal	<input type="checkbox"/> Back <input type="checkbox"/> Front <input type="checkbox"/> External	
<input type="checkbox"/> Face	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Jaw	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Eye	<input type="checkbox"/> Left <input type="checkbox"/> Right	Sight effected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Torso	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Back	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Arm	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Hand	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Back <input type="checkbox"/> Palm <input type="checkbox"/> Finger/s	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Leg	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Internal <input type="checkbox"/> External

First Aid and Medical Treatment

Did you require any medical treatment? <input type="checkbox"/> First Aid Only <input type="checkbox"/> General Practitioner Consulted <input type="checkbox"/> Hospital Emergency/Out-patient <input checked="" type="checkbox"/> Hospital In-Patient <input type="checkbox"/> Other, please specify:
First Aid treatment provided by, Name: Address:
Details of treatment:

Name of person making entry:	Date:
Signature:	

