

**THE EUROPEAN REGISTER OF EXERCISE PROFESSIONAL
EREPS INSURANCE SCHEME**

August 2008



MORE PEOPLE | MORE ACTIVE | MORE OFTEN

INCIDENT REPORT FORM

FITNESS INSTRUCTOR NAME _____

EREPS REGISTRATION NUMBER _____

CONTACT TELEPHONE NUMBER INC INTERNATIONAL CODE _____

DATE REPORTED: _____ TIME REPORTED: _____

EXACT LOCATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ DAY OF WEEK: _____

INCIDENT REPORTED BY: _____ INCIDENT REPORTED TO: _____

TIME INCIDENT LOCATION INSPECTED: _____ INSPECTED BY: _____

Fax

PART 1: INJURED PERSON DETAILS

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) MALE FEMALE

WALKING STICK GLASSES CARRYING GOODS OTHER IMPAIRMENTS

PART 2: WITNESS * DETAILS

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment.

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

NAME OF WITNESS TO ACCIDENT:

(Surname) (Given Names)

ADDRESS OF WITNESS:

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

TYPE OF WITNESS: EYE WITNESS CIRCUMSTANTIAL WITNESS

RELATIONSHIP TO INJURED PERSON:

(If more than one witness, please provide details)

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS:

PART 3: PERSONAL INJURY DETAILS

PART OF BODY INJURED (Place tick in appropriate box)

- | | | | | | |
|--------------|--------------------------|---------------|--------------------------|----------------|--------------------------|
| Head & Neck | <input type="checkbox"/> | Hip | <input type="checkbox"/> | Hands/ Fingers | <input type="checkbox"/> |
| Eyes or Face | <input type="checkbox"/> | Shoulder | <input type="checkbox"/> | Knee | <input type="checkbox"/> |
| Back & Trunk | <input type="checkbox"/> | Arms / Wrists | <input type="checkbox"/> | Feet and toes | <input type="checkbox"/> |

If Other, or multiple, please describe:

NATURE OF INJURY (Place tick in appropriate box)

- | | | | | | |
|-----------------|--------------------------|------------------------------------|--------------------------|--|--------------------------|
| Multiple | <input type="checkbox"/> | Minor Bruise - Not Disabling | <input type="checkbox"/> | Concussion/Unconscious (Serious) | <input type="checkbox"/> |
| Fracture | <input type="checkbox"/> | Major Bruising - Disabling | <input type="checkbox"/> | Burns/Scalds – requiring medical attention | <input type="checkbox"/> |
| Sprain | <input type="checkbox"/> | Minor Cut/Laceration - No Stitches | <input type="checkbox"/> | Superficial | <input type="checkbox"/> |
| Dislocation | <input type="checkbox"/> | Cut/Laceration requiring Stitches | <input type="checkbox"/> | No Apparent Injury | <input type="checkbox"/> |
| Ligament Damage | <input type="checkbox"/> | Minor Concussion | <input type="checkbox"/> | | |

If Other, describe:

DESCRIPTION OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)

DESCRIPTION OF INCIDENT INCLUDING ACTIVITY BEING UNDERTAKEN (by you or independent witness)

WAS THE INJURED PERSON TAKEN TO: TREATMENT BY FIRST AIDER DOCTOR/HOSPITAL
AMBULANCE

NAME OF FIRST AIDER/ PERSON ATTENDING: _____ CONTACT NO: _____

OTHER (Please describe): _____

IF THIRD PARTY/CONTRACTOR AT FAULT: THIRD PARTY/CONTRACTOR'S NAME: _____

THIRD PARTY/CONTRACTOR'S INSURANCE DETAILS: _____

PART 4: PROPERTY DAMAGE (complete if there is property damage)

ITEM DAMAGED: _____

DETAILS:

IF VIEWED AND BY WHOM:

PHOTOS TAKEN AND BY WHOM: _____

PART 5: LOCATION OF INCIDENT (Please tick in appropriate box)

- | | | | | | |
|--------------|--------------------------|-----------------------------|--------------------------|--------|--------------------------|
| On Equipment | <input type="checkbox"/> | Basketball Court or Similar | <input type="checkbox"/> | Stairs | <input type="checkbox"/> |
|--------------|--------------------------|-----------------------------|--------------------------|--------|--------------------------|

- | | | | | | |
|--------------------|--------------------------|--------------------|--------------------------|-----------------|--------------------------|
| In Gym Common Area | <input type="checkbox"/> | Office Areas | <input type="checkbox"/> | Moving Walkways | <input type="checkbox"/> |
| Playing Field | <input type="checkbox"/> | Internal Ramp | <input type="checkbox"/> | Elevators | <input type="checkbox"/> |
| Beach | <input type="checkbox"/> | Children Play Area | <input type="checkbox"/> | Park Area | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | | | | |

If Other, describe: _____

PART 6: TYPE OF INCIDENT (Please tick in appropriate box)

Injury of Person By:

- | | | | | | |
|--------------------------|--------------------------|-----------------------|--------------------------|----------------------------|--------------------------|
| Whilst Using Equipment | <input type="checkbox"/> | Lack of Barrier | <input type="checkbox"/> | Uneven Floor | <input type="checkbox"/> |
| Whilst Warming Up | <input type="checkbox"/> | Rainwater on floor | <input type="checkbox"/> | Tripped over Object | <input type="checkbox"/> |
| Collision | <input type="checkbox"/> | Steps/Stairs | <input type="checkbox"/> | Not Following Instructions | <input type="checkbox"/> |
| Floor Slippery (Surface) | <input type="checkbox"/> | Not Familiar Exercise | <input type="checkbox"/> | Equipment Failure | <input type="checkbox"/> |
| Inadequate Lighting | <input type="checkbox"/> | Over Exertion | <input type="checkbox"/> | No apparent Reason | <input type="checkbox"/> |

If Other, describe: _____

Type of surface:

- | | | | | | | | |
|----------|--------------------------|----------|--------------------------|---------|--------------------------|-------------------|--------------------------|
| Marble | <input type="checkbox"/> | Tile | <input type="checkbox"/> | Carpet | <input type="checkbox"/> | Dirt/grass/garden | <input type="checkbox"/> |
| Terrazzo | <input type="checkbox"/> | Timber | <input type="checkbox"/> | Bitumen | <input type="checkbox"/> | Slate | <input type="checkbox"/> |
| Vinyl | <input type="checkbox"/> | Concrete | <input type="checkbox"/> | Other | <input type="checkbox"/> | | |

If Other, describe: _____

Caught in:

- | | | | | | |
|------|--------------------------|---------------------|--------------------------|-------|--------------------------|
| Door | <input type="checkbox"/> | Machinery/Equipment | <input type="checkbox"/> | Other | <input type="checkbox"/> |
|------|--------------------------|---------------------|--------------------------|-------|--------------------------|

If Other, describe: _____

Stepping on or Striking Against:

- | | | | |
|--------------------------------|--------------------------|-------|--------------------------|
| Fitness Equipment | <input type="checkbox"/> | Doors | <input type="checkbox"/> |
| Sharp Edges/Protruding Objects | <input type="checkbox"/> | Other | <input type="checkbox"/> |

If Other, describe: _____

Other:

- Falling Objects If Falling objects, please describe: _____
 Water Damage

WAS THE INJURED PERSON Reasonable Upset Aggressive Add relevant comments: _____

CLEANERS ON DUTY: _____ **CLEANING SUPERVISOR:** _____

TIME LOCATION LAST INSPECTED: _____ TIME LAST CLEANED: _____

PLEASE ATTACH WRITTEN STATEMENT FROM CLEANER (If appropriate)

RECORD OF INCIDENT Video/closed circuit Photo None