



Mountain Bike Australia Incident Report Form

Incident Details

Date of incident: _____ Time of incident: _____

Venue / Location: _____

Club / Private Promoter: _____

Incident category: Injury* Public property damage
 Complaint Event vehicle damage
 Contracted goods and services Inappropriate behaviour
 Other: _____

Incident Details (please be as specific as possible, including all relevant information in relation to contributing factors):

Do you have photographs of the incident? Yes No Do you have video of the incident? Yes No

Has property been _____ Damage or Stolen

Property type: _____ Approximate property value: _____

Witness Details

Witness name: _____ Daytime Phone: _____

Witness name: _____ Daytime Phone: _____

Witness name: _____ Daytime Phone: _____

Acknowledgement (Race Director or Club Official)

Person completing form: _____ Position: _____

Signed: _____ Phone: _____

* Important: Please also complete the reverse side for injuries or public damage.

Instructions: 1) Fill out all information you are able to provide.

2) Post or email to MTBA within 1 day of the incident:

Mountain Bike Australia
PO Box 377
Varsity Lakes QLD 4227
info@mtba.org.au

3) Provide any supporting information you can (medical reports, police reports etc) if possible.

Personal Details *(of injured person / person reporting damage)*

First Name: _____ Surname: _____

Gender: Male Female Date of Birth: ____ / ____ / ____

Phone: _____ Mobile: _____

Postal Address: _____

City: _____ State: _____ Postcode: _____

Member Status: MTBA Member Member number: _____

Race Day Licence Licence number: _____

Involvement: Public / Spectator Athlete Volunteer

Contractor Officials Event Staff

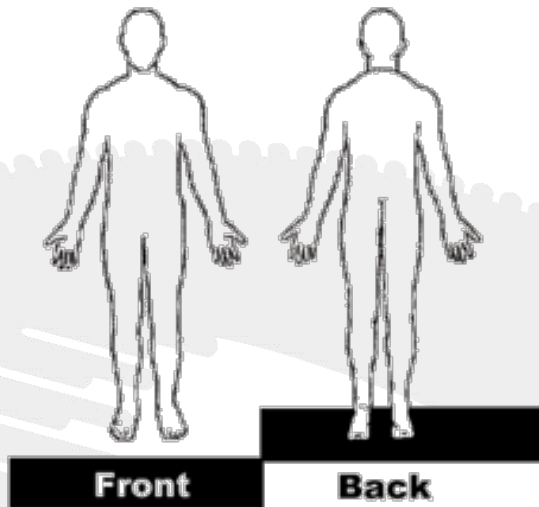
Other: _____

Injury Details

Nature of Injury: _____

Body area:

(Please circle)



Cause of injury: _____

Manner of injured person: Reasonable Distressed Aggressive

Treatment

Was first aid supplied on site? Yes No

Location of initial treatment: _____

Treatment supplied by: Event medical staff Other: _____

Name of treatment provider: _____ Phone: _____

Referred to hospital? Yes No Ambulance required? Yes No

Additional information: _____

Is MTBA follow up needed? Yes No

MTBA Office Use Only

Date Received: _____ Initial: _____ Insurance claim? Yes No