Port Moody Curling Club Accident Report

Patient Information (Shaded fields are required)

First Name:	**Last Name:**
Street Address:	
City:	Postal Code:
Phone:	Email:

Incident Information

Date of Incident:	**Time of Incident:**
Describe the Incident:	
Actions Taken:	

Incident Witnesses

Name:
Contact Info: (phone and/or email):
Name:
Contact Info: (phone and or/email):
After on-ice treatment, the patient was: ☐ Sent Home ☐ Sent to Hospital by Ambulance ☐ Sent to Hospital by other ☐ Return to Activity

Completed By

Name:	**Phone &/or email**

After completing this form, scan and send to Club Manager: manager@portmoodycurling.ca

DO NOT LEAVE THE COMPLETED FORM IN THE FIRST AID KIT