



Direct Bearing Network Resource

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The Direct Bearing Network



The Direct Bearing Network represents a group of people responsible for risk management in their organizations.

Members gain access to risk management related articles, studies, tools, templates and links to quality resources that have been vetted by the Direct Bearing Team.

The Network also serves to put you in touch with other people working in similar areas with challenges not unlike your own.

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Incident Report

Course _____ Day # _____ CL name _____

Staff _____ # Participants _____

Name _____ (circle) Male/Female Staff/Student Age _____

Incident Date _____ Time _____ AM/PM

Geographical Location of Incident _____

WEATHER at Time of Incident:

Temp (°C) _____ Precipitation (circle) Rain or Snow or None
 Wind (mph) _____ Visibility _____ (m or km)

Surface Condition (circle) wet dry snow ice trail rock uneven flat sloped

TYPE OF INCIDENT: Check each applicable category:

Injury _____ Illness _____ Motivation/Behaviour _____ Near Miss _____
 Is this a Lost-Day case? _____ NO _____ YES If Yes, # of Days Lost _____
 Did the victim leave the field? _____ NO _____ YES If Yes, on what date _____
 Evacuation method(circle) walk unassisted, litter, vehicle, helicopter, other _____
 Did the victim visit a medical facility? _____ NO _____ YES If Yes, # of hours/days _____
 Did the victim return to the course? _____ NO _____ YES If Yes, on what date _____
 Was there damage to (circle) vehicle, equipment or property?

TYPE OF INJURY (check all that apply)

<input type="checkbox"/> bruise, contusion or similar soft-tissue trauma	<input type="checkbox"/> immersion foot
<input type="checkbox"/> ligament sprain	<input type="checkbox"/> tendonitis
<input type="checkbox"/> muscle strain	<input type="checkbox"/> eye injury
<input type="checkbox"/> frostbite	<input type="checkbox"/> dental or tooth-related
<input type="checkbox"/> fracture	<input type="checkbox"/> burn
<input type="checkbox"/> dislocation	<input type="checkbox"/> blister(s)
<input type="checkbox"/> head injury <i>without</i> loss of consciousness	<input type="checkbox"/> laceration
<input type="checkbox"/> head injury <i>with</i> loss of consciousness	<input type="checkbox"/> skin abrasions
<input type="checkbox"/> near drowning or other submersion problem	<input type="checkbox"/> sunburn
<input type="checkbox"/> other _____	

ANATOMICAL LOCATION OF INJURY (check or circle)

<input type="checkbox"/> Head	<u>L/R</u> Upper Back	<u>L/R</u> Hip	<u>L/R</u> Shoulder
<input type="checkbox"/> Neck	<u>L/R</u> Lower back	<u>L/R</u> Thigh	<u>L/R</u> Upper Arm
<input type="checkbox"/> Face	<u>L/R</u> Chest	<u>L/R</u> Knee	<u>L/R</u> Elbow
<u>L/R</u> Eye	<u>L/R</u> Abdomen	<u>L/R</u> Lower Leg	<u>L/R</u> Forearm
<input type="checkbox"/> Nose	<u>L/R</u> Pelvis	<u>L/R</u> Ankle	<u>L/R</u> Wrist
<input type="checkbox"/> Mouth		<u>L/R</u> Foot	<u>L/R</u> Hand/Fingers
		<u>L/R</u> Toe	

TYPE OF ILLNESS (check all that apply)

allergic reaction (_____ mild or localized _____ severe, generalized or anaphylaxis)
 hypothermia (specify core temperature if known _____ oF / _____ oC)
 heat illness (specify core temperature if known _____ oF / _____ oC) heat exhaustion cramps stroke
 chest pain or cardiac condition
 upper respiratory illness (runny nose, congestion, "cold")
 upper respiratory illness (other) _____
 abdominal or other gastrointestinal problem without diarrhea
 diarrhea
 apparent food-related illness
 nonspecific fever illness
 urinary tract infection
 skin infection
 eye infection (L / R)
 other _____

