

MOVE UNITED INCIDENT REPORT FORM



Please submit a signed waiver & registration form for injured person, along with this form, within 24 hours of incident
 Two page form must be completed by official chapter representative – please print legibly

Date of Incident:		Time of Incident:	
Chapter Name:			
INJURED PERSON INFORMATION			
First Name:		Middle Initial:	Last Name:
Phone Number:		Date of Birth:	Age:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Other: _____			
Address:		City:	State: Zip:
Disability:			<input type="checkbox"/> N/A
Injured Person: <input type="checkbox"/> Participant <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____			
PARENT/LEGAL GUARDIAN (IF INJURED PERSON IS A MINOR OR LEGALLY INCAPACITATED)			
First Name:		Last Name:	Phone Number:
Address:		City:	State: Zip:
INJURY INFORMATION			
PRIMARY INJURY RESULTING FROM INCIDENT:		BODY PART INJURED:	
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Ankle (L / R)	<input type="checkbox"/> Internal
<input type="checkbox"/> Allergy	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Arm (L / R)	<input type="checkbox"/> Knee (L / R)
<input type="checkbox"/> Amputation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Back	<input type="checkbox"/> Leg (L / R)
<input type="checkbox"/> Burn	<input type="checkbox"/> Illness	<input type="checkbox"/> Ear (L / R)	<input type="checkbox"/> Neck
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Nausea	<input type="checkbox"/> Elbow (L / R)	<input type="checkbox"/> Nose
<input type="checkbox"/> Cold Injury	<input type="checkbox"/> Pain	<input type="checkbox"/> Eye (L / R)	<input type="checkbox"/> Shoulder (L / R)
<input type="checkbox"/> Concussion	<input type="checkbox"/> Seizures	<input type="checkbox"/> Face	<input type="checkbox"/> Toe
<input type="checkbox"/> Contusion	<input type="checkbox"/> Sting/Bite	<input type="checkbox"/> Finger	<input type="checkbox"/> Tooth
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Foot (L / R)	<input type="checkbox"/> Torso
<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hand (L / R)	<input type="checkbox"/> Wrist (L / R)
<input type="checkbox"/> Fracture	<input type="checkbox"/> Tooth/Mouth	<input type="checkbox"/> Head	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Hip	
INCIDENT INFORMATION			
PRIMARY CAUSE OF INCIDENT:			
<input type="checkbox"/> Animal bite/sting	<input type="checkbox"/> Assault/non-sexual	<input type="checkbox"/> Collision with person	<input type="checkbox"/> Struck by falling /flying object
<input type="checkbox"/> Aquatic	<input type="checkbox"/> Caught in, on, between	<input type="checkbox"/> Fall/Slip	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Assault/sexual	<input type="checkbox"/> Collision with object	<input type="checkbox"/> Fall from height	
INCIDENT LOCATION: <input type="checkbox"/> Activity Site <input type="checkbox"/> Administrative Premises/Grounds <input type="checkbox"/> Off Property <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING:			
<input type="checkbox"/> Lesson <input type="checkbox"/> Competition <input type="checkbox"/> Training <input type="checkbox"/> Guiding <input type="checkbox"/> Other: _____			
WEATHER CONDITIONS: <input type="checkbox"/> Clear <input type="checkbox"/> Icy <input type="checkbox"/> Fog <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____			
INCIDENT TOOK PLACE DURING WHAT SPORT/ACTIVITY:			
EQUIPMENT INVOLVED IN INCIDENT:			

PLEASE COMPLETE 2ND PAGE

The completed incident report is an internal document to be shared with Move United and our insurer only.

Revised 12/2022

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Report and waiver must be submitted within 24 hours of incident to:
 Willis Towers Watson at claimcentral@willistowerswatson.com.

