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: ❑ Male ❑ Female ❑ Prefer not to answer ❑ Other: _____			
Address:	City:	State:	Zip:
Disability: ❑ N/A			
Injured Person: ❑ Participant ❑ Employee ❑ Volunteer ❑ 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:

❑ Abrasion
❑ Allergy
❑ Amputation
❑ Burn
❑ Cardiac
❑ Cold Injury
❑ Concussion
❑ Contusion
❑ Dislocation
❑ Foreign Body
❑ Fracture
❑ Heat Exhaustion
❑ Hypertension
❑ Hypothermia
❑ Laceration
❑ Illness
❑ Nausea
❑ Pain
❑ Seizures
❑ Sting/Bite
❑ Strain/Sprain
❑ Stroke
❑ Tooth/Mouth
❑ Other: _____

BODY PART INJURED:

❑ Ankle (L / R)
❑ Arm (L / R)
❑ Back
❑ Ear (L / R)
❑ Elbow (L / R)
❑ Eye (L / R)
❑ Face
❑ Finger
❑ Foot (L / R)
❑ Hand (L / R)
❑ Head
❑ Hip
❑ Internal
❑ Knee (L / R)
❑ Leg (L / R)
❑ Neck
❑ Nose
❑ Shoulder (L / R)
❑ Toe
❑ Tooth
❑ Torso
❑ Wrist (L / R)
❑ Other: _____

INCIDENT INFORMATION

PRIMARY CAUSE OF INCIDENT:

❑ Animal bite/sting
❑ Aquatic
❑ Assault/sexual
❑ Assault/non-sexual
❑ Caught in, on, between
❑ Collision with object
❑ Collision with person
❑ Fall/Slip
❑ Fall from height
❑ Struck by falling /flying object
❑ Other: _____

INCIDENT LOCATION: ❑ Activity Site ❑ Administrative Premises/Grounds ❑ Off Property ❑ Other: _____

INCIDENT TOOK PLACE DURING:

❑ Lesson ❑ Competition ❑ Training ❑ Guiding ❑ Other: _____

WEATHER CONDITIONS: ❑ Clear ❑ Icy ❑ Fog ❑ Rain ❑ Snow ❑ N/A ❑ 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 11/2025

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

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DESCRIPTION OF INCIDENT
Please be as descriptive as possible and include all relevant information, including: Who was involved (please provide names and roles)? Where were they? What happened? What was the sequence of events? *Attach a separate sheet if necessary.*

RESPONSE TO INCIDENT		
Please list any first aid or medical treatment provided at the time of incident? ❑ Refused Treatment		
WHAT AID OR TREATMENT WAS PROVIDED?	**WHO PROVIDED THE TREATMENT?**	**WHERE WAS AID OR TREATMENT PROVIDED?**

PLEASE CHECK ALL THAT APPLY:

❑ Transported by ambulance to hospital
❑ Transported by air ambulance to hospital
❑ Transported by ambulance to hospital at the request of patient/parent/guardian
❑ Self-transported to hospital or clinic
❑ Referred to doctor
❑ Referred to hospital or clinic
❑ Released to parent/guardian
❑ Released to self
❑ Ski patrol assisted
❑ Police involved
❑ Other:_____
_____

If individual is a minor or legally incapacitated, was the parent/legal guardian notified? ❑ Yes ❑ No *If yes, when?*

Any additional information?

WITNESS INFORMATION				
NAME	**ROLE**	**ADDRESS**	**ZIP CODE**	**PHONE NUMBER**

REPORTER'S INFORMATION		
Name:	Position:	Date:
Address:	Phone Number:	

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