

SANFORD-SPRINGVALE FISH & GAME PROTECTIVE ASSOCIATION
INCIDENT REPORT FORM

Incident Report

Report # _____

1. INCIDENT PROFILE

1. Incident Type

- | | |
|---|---|
| <input type="checkbox"/> Fatal | <input type="checkbox"/> Property Damage Only |
| <input type="checkbox"/> Non-Fatal | <input type="checkbox"/> Firearm |
| <input type="checkbox"/> Self-Inflicted | <input type="checkbox"/> Bow |
| <input type="checkbox"/> Other, | |

2. Date of Incident _____

3. Time _____

4. Range Name or Area Information

Name: _____

Address: _____

Phone: _____

5. Was injury self-inflicted?

- | | |
|---|--|
| <input type="checkbox"/> YES - Complete sections: | <input type="checkbox"/> NO – Complete sections: |
| 1. Incident Profile | 1. Incident Profile |
| 2. Shooter | 2. Shooter |
| | 3. Victim |

6. Lighting:

- | | |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Dawn |
| <input type="checkbox"/> Dark | <input type="checkbox"/> Overcast |
| <input type="checkbox"/> Dusk | <input type="checkbox"/> Sunny |

7. Visibility:

- | | |
|------------------------------------|----------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Good | |
| <input type="checkbox"/> Poor | |

8. Incident occurred in:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Trap Field | <input type="checkbox"/> 100yd Range #1 (Sanford) | <input type="checkbox"/> Archery – Range |
| <input type="checkbox"/> 25yd Range | <input type="checkbox"/> 100yd Range #2 (Sanford) | <input type="checkbox"/> Archery – 3D |
| <input type="checkbox"/> 50yd Range | <input type="checkbox"/> 100/200yd Range (Berwick) | <input type="checkbox"/> Other: |

9. Contributing Factor(s) (List most important factor as “1” in space below next to letter, 2nd as “2”, etc.)

- | | |
|---|--|
| _____ A. Victim moved into line of fire | _____ J. Careless or reckless handling of firearm |
| _____ B. Ricochet | _____ K. Place/remove firearm from vehicle |
| _____ C. Defective firearm ammunition | _____ L. Drop firearm |
| _____ D. Firearm fell, insecure rest | _____ M. Horse play while hunting |
| _____ E. Shooter stumbled and fell | _____ N. Run with loaded firearm |
| _____ F. Trigger caught on object | _____ O. Obstruction of barrel |
| _____ G. Loading firearm | _____ P. Careless handling of archery equipment |
| _____ H. Unloading firearm | _____ Q. Discharge of firearm when firing line is closed |
| _____ I. Discharge of firearm in/on a vehicle | _____ R. Other: |

10. Based on the contributing factors, what could have been done differently to prevent this incident from occurring?

11. Witnesses other than shooter or victim

Name	Address (Street, City, State, Zip)	Phone Number

12. Reported By:

Name: _____ Date: _____ Time: _____

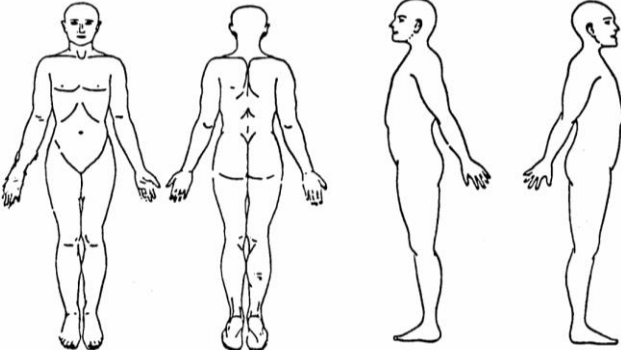
Reported To:

Name: _____ Position: _____

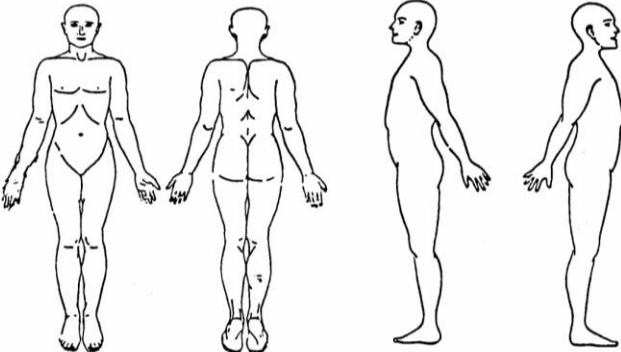
13. Report Completed By:

Name: _____ Signature _____ Date _____

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Report #					
2. SHOOTER					
1. Name (Last, First, MI)			2. Gender		3. DOB
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
4. Address		5. City		6. State	7. Zip Code 8. Membership Status <input type="checkbox"/> Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Guest of Member
9. Years of Firearm Handling Experience:					
10. Shooter Used Intoxicants Prior to Incident: A. Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown B. Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Illegal: <input type="checkbox"/> Yes <input type="checkbox"/> No			11. Failure to use prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
12. Were shooter and victim at shooting range together? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			13. Relationship of shooter to victim:		
14. Has shooter ever been involved in a range incident before? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Firearm/Instrument used: <input type="checkbox"/> Shotgun <input type="checkbox"/> Air/Gas Gun <input type="checkbox"/> Rifle <input type="checkbox"/> Other: <input type="checkbox"/> Handgun <input type="checkbox"/> Bow <input type="checkbox"/> Crossbow		16. Type of Action: <input type="checkbox"/> Bolt <input type="checkbox"/> Caplock <input type="checkbox"/> Lever <input type="checkbox"/> Inline <input type="checkbox"/> Pump <input type="checkbox"/> Revolver <input type="checkbox"/> Break/Hinge <input type="checkbox"/> Other: <input type="checkbox"/> Semi-Auto		17. Type of Sight: <input type="checkbox"/> Open <input type="checkbox"/> Peep <input type="checkbox"/> Scope <input type="checkbox"/> Other:	
18. Make:		19. Model:		20. Serial Number:	21. Caliber/Gauge:
22. Capacity: <input type="checkbox"/> Repeater <input type="checkbox"/> Double Barrel <input type="checkbox"/> Single Shot <input type="checkbox"/> N/A		23. Projectile Type: <input type="checkbox"/> Bullet – Caliber Weight <input type="checkbox"/> Arrow <input type="checkbox"/> Slug - Gauge Weight <input type="checkbox"/> Shot - Size Material <input type="checkbox"/> Other		24. Ammunition: <input type="checkbox"/> Factory <input type="checkbox"/> Reload <input type="checkbox"/> Unknown	
				25. Safety Position: <input type="checkbox"/> On <input type="checkbox"/> Off <input type="checkbox"/> N/A <input type="checkbox"/> Defective <input type="checkbox"/> Unknown	
26. Diagram Injuries 				27. Describe Injuries (Be Specific) – if no injuries, describe property damage and list value:	
28. Injury Severity: <input type="checkbox"/> Debilitating <input type="checkbox"/> Severe <input type="checkbox"/> Fatal <input type="checkbox"/> Unknown <input type="checkbox"/> Minor <input type="checkbox"/> N/A <input type="checkbox"/> Moderate		29. Name of Physician		30. Name of Medical Facility	
				31. In case of death, name of Coroner/Medical Examiner	

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Report #					
2. VICTIM					
1. Name (Last, First, MI)			2. Gender		3. DOB
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
4. Address		5. City	6. State	7. Zip Code	8. Membership Status
					<input type="checkbox"/> Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Guest of Member
9. Years of Firearm Handling Experience:					
10. Victim Used Intoxicants Prior to Incident:			11. Failure to use prescribed medication?		
A. Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown B. Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Illegal: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
12. Were shooter and victim at shooting range together?			13. Relationship of shooter to victim:		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
14. Has victim ever been involved in a range incident before?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Firearm/Instrument used:		16. Type of Action:		17. Type of Sight:	
<input type="checkbox"/> Shotgun <input type="checkbox"/> Air/Gas Gun <input type="checkbox"/> Rifle <input type="checkbox"/> Other: <input type="checkbox"/> Handgun <input type="checkbox"/> Bow <input type="checkbox"/> Crossbow		<input type="checkbox"/> Bolt <input type="checkbox"/> Caplock <input type="checkbox"/> Lever <input type="checkbox"/> Inline <input type="checkbox"/> Pump <input type="checkbox"/> Revolver <input type="checkbox"/> Break/Hinge <input type="checkbox"/> Other: <input type="checkbox"/> Semi-Auto		<input type="checkbox"/> Open <input type="checkbox"/> Peep <input type="checkbox"/> Scope <input type="checkbox"/> Other:	
18. Make:		19. Model:	20. Serial Number:		21. Caliber/Gauge:
22. Capacity:		23. Projectile Type:		24. Ammunition:	25. Safety Position:
<input type="checkbox"/> Repeater <input type="checkbox"/> Double Barrel <input type="checkbox"/> Single Shot <input type="checkbox"/> N/A		<input type="checkbox"/> Bullet – Caliber Weight <input type="checkbox"/> Arrow <input type="checkbox"/> Slug - Gauge Weight <input type="checkbox"/> Shot - Size Material <input type="checkbox"/> Other		<input type="checkbox"/> Factory <input type="checkbox"/> Reload <input type="checkbox"/> Unknown	<input type="checkbox"/> On <input type="checkbox"/> Off <input type="checkbox"/> N/A <input type="checkbox"/> Defective <input type="checkbox"/> Unknown
26. Diagram Injuries			27. Describe Injuries (Be Specific) – if no injuries, describe property damage and list value:		
					
28. Injury Severity:		29. Name of Physician	30. Name of Medical Facility	31. In case of death, name of Coroner/Medical Examiner	
<input type="checkbox"/> Debilitating <input type="checkbox"/> Severe <input type="checkbox"/> Fatal <input type="checkbox"/> Unknown <input type="checkbox"/> Minor <input type="checkbox"/> N/A <input type="checkbox"/> Moderate					