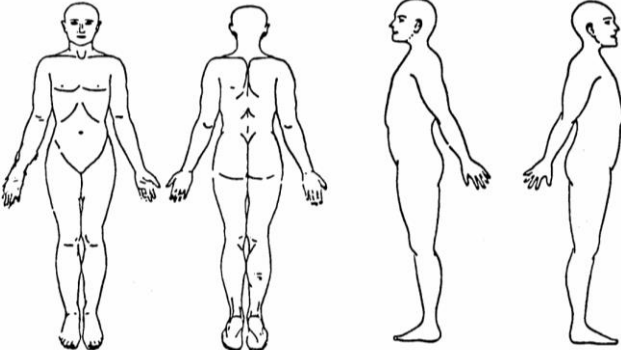


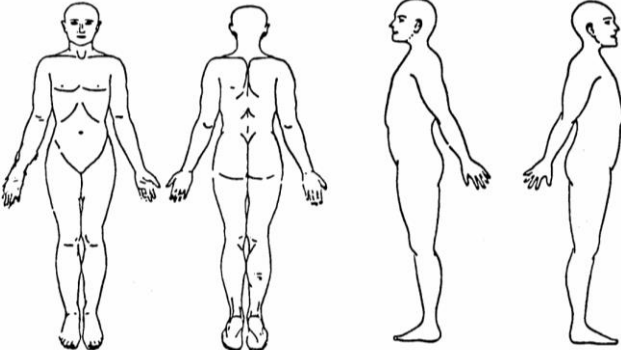
Incident Report

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: 1. Incident Profile 2. Shooter <input type="checkbox"/> NO – Complete sections: 1. Incident Profile 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.) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> _____ A. Victim moved into line of fire _____ B. Ricochet _____ C. Defective firearm ammunition _____ D. Firearm fell, insecure rest _____ E. Shooter stumbled and fell _____ F. Trigger caught on object _____ G. Loading firearm _____ H. Unloading firearm _____ I. Discharge of firearm in/on a vehicle </td> <td style="width: 50%; border: none;"> _____ J. Careless or reckless handling of firearm _____ K. Place/remove firearm from vehicle _____ L. Drop firearm _____ M. Horse play while hunting _____ N. Run with loaded firearm _____ O. Obstruction of barrel _____ P. Careless handling of archery equipment _____ Q. Discharge of firearm when firing line is closed _____ R. Other: _____ </td> </tr> </table>			_____ A. Victim moved into line of fire _____ B. Ricochet _____ C. Defective firearm ammunition _____ D. Firearm fell, insecure rest _____ E. Shooter stumbled and fell _____ F. Trigger caught on object _____ G. Loading firearm _____ H. Unloading firearm _____ I. Discharge of firearm in/on a vehicle	_____ J. Careless or reckless handling of firearm _____ K. Place/remove firearm from vehicle _____ L. Drop firearm _____ M. Horse play while hunting _____ N. Run with loaded firearm _____ O. Obstruction of barrel _____ P. Careless handling of archery equipment _____ Q. Discharge of firearm when firing line is closed _____ R. Other: _____
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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 _____				

SANFORD-SPRINGVALE FISH & GAME PROTECTIVE ASSOCIATION
INCIDENT REPORT FORM

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:			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 shooter 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					

SANFORD-SPRINGVALE FISH & GAME PROTECTIVE ASSOCIATION
INCIDENT REPORT FORM

Report # _____				
2. VICTIM				
1. Name (Last, First, MI)				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; height: 20px;"></td> <td style="width: 30%; height: 20px;"></td> <td style="width: 30%; height: 20px;"></td> </tr> </table>				
2. Gender				
<input type="checkbox"/> Male <input type="checkbox"/> Female				
3. DOB				
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:				
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 victim 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				