



HEALTH CLUB INCIDENT REPORT FORM

Information: (Member Involved / Witnesses)

Member's Name Involved in Incident: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: _____		
Member's Phone Number: (Home) _____	(Work) _____			
Member Address:	Street	City	State	Zip
Report Date (Today's Date): _____				
Manager on Duty at Time of Incident: _____				
Witness' Name #1 _____	Phone Number _____			
Witness' Name #2 _____	Phone Number _____			

Accident / Injury Report

Date of Incident:	_____		
Time of accident:	_____	<input type="checkbox"/> AM	<input type="checkbox"/> PM
Cause of injury:	_____		
Client injured by:	<input type="checkbox"/> Self-inflicted	<input type="checkbox"/> Staff member	<input type="checkbox"/> Other member
Incident Occurred:	<input type="checkbox"/> Entering facility	<input type="checkbox"/> Inside of facility	<input type="checkbox"/> While exercising
	<input type="checkbox"/> Exiting facility	<input type="checkbox"/> Outside of facility	<input type="checkbox"/> Other: _____
Specific area where injury occurred:	<input type="checkbox"/> Aerobic areas / studios	<input type="checkbox"/> Spa / Jacuzzi area	<input type="checkbox"/> Tennis / Racquetball courts
	<input type="checkbox"/> Cardiovascular areas	<input type="checkbox"/> Steps / hallways / local areas	<input type="checkbox"/> Track / running area
	<input type="checkbox"/> Child Care area	<input type="checkbox"/> Swimming area / pool	<input type="checkbox"/> Weight room area
	<input type="checkbox"/> Locker Rooms / Shower	<input type="checkbox"/> Tanning area	<input type="checkbox"/> Other: _____
Type of injury:	<input type="checkbox"/> Abrasion/scratch	<input type="checkbox"/> Fracture/break	<input type="checkbox"/> Sprain/strain
	<input type="checkbox"/> Contusion/bruise	<input type="checkbox"/> Laceration/cut	<input type="checkbox"/> Other: _____
Action Taken:	<input type="checkbox"/> None	<input type="checkbox"/> First Aid treatment by Staff	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Referred to Doctor Doctor's Name: _____	<input type="checkbox"/> Referred to nurse Nurse's Name: _____	<input type="checkbox"/> Transported to hospital: Name of hospital: _____
	Person Notified: _____		Time Notified: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Treatment Provided:	<input type="checkbox"/> None	<input type="checkbox"/> First aid	<input type="checkbox"/> Medical office visit
	<input type="checkbox"/> Emergency room /outpatient	<input type="checkbox"/> Inpatient services	<input type="checkbox"/> Other: _____
Part of body injured:	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eye	<input type="checkbox"/> Leg
	<input type="checkbox"/> Arm	<input type="checkbox"/> Foot / toes / ankle	<input type="checkbox"/> Mouth / Teeth
	<input type="checkbox"/> Back	<input type="checkbox"/> Hand / fingers	<input type="checkbox"/> Neck
	<input type="checkbox"/> Chest	<input type="checkbox"/> Head / skull	<input type="checkbox"/> Nose
	<input type="checkbox"/> Ear	<input type="checkbox"/> Knee	<input type="checkbox"/> Other: _____

The information and suggestions presented by National Health Club Association in this loss control technical resource form are for your consideration in your loss prevention and risk control efforts. They are not intended to be complete in identifying or reporting on every possible or significant hazard at your premises, preventing possible workplace accidents, or complying with all of the local, state or federal health & safety related laws or regulations. The material enclosed within this loss control reference source is intended and encouraged to be altered or redesigned by you to specifically address your hazards.

Describe Clearly How the Incident Occurred:

Witnesses Account of Incident:

Analysis (What Acts and / or conditions directly contributed to the incident?):

Corrective Action (What actions have or will be taken to prevent recurrence):

Corrective Action Follow-Up Date:	_____
Investigated By (Signature):	_____
Date:	_____
Reviewed By (Signature):	_____
Date:	_____