

ACCIDENT REPORT

Motorsports Oval Tracks

(Check and/or circle one per section, complete relevant blanks)

INJURED: (Driver) (Pit Crew) (Official) (Spectator) (Other _____)						
Name: _____			Age: _____		Sex: (M) (F)	
Address: _____						
City: _____	Prov. _____	PC: _____	Phone: _____	(_____)		
Years Experience: (1 st) (1-3) (4-9) (10+)						
TRACK NAME/LOCATION: _____					(Indoor)	(Outdoor)
Policy #: _____		Sanctioned by: _____				
Race: _____	Track Length: _____					

INJURY:	TIME	DISPOSITION
DATE OF INJURY: _____	<input type="checkbox"/> Morning	<input type="checkbox"/> On-Site Care Only
INJURED BODY PART: _____	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Ambulance to: _____
CONDITION: _____ (Sprain, Fracture, Concussion, etc.)	<input type="checkbox"/> Evening	City _____
	<input type="checkbox"/> Lights	
ESTIMATED ABSENCE FROM WORK: (1-7 days) (1-3 weeks) (3+ weeks)		<input type="checkbox"/> Fatality
DOES INJURED DRIVER HAVE OTHER INSURANCE? (Y) (N) Company: _____		

TYPE:		
<input type="checkbox"/> STOCK CAR (Modified) (Super Mod) (Street) (Demo)	<input type="checkbox"/> MOTORCYCLE (CLASS _____)	
<input type="checkbox"/> OPEN WHEEL (Midget) (Sprint) (Outlaw) (Modified) (CART) (Indy Car)	<input type="checkbox"/> VINTAGE	
<input type="checkbox"/> TRUCK (Pick-up) (Semi)	<input type="checkbox"/> GO-KART (Sprint) (Enduro)	<input type="checkbox"/> OTHER

OCCASION:	LOCATION:	ACTIVITY:
<input type="checkbox"/> PRE-RACE	<input type="checkbox"/> LOADING AREA (Garage)	<input type="checkbox"/> PASSING
<input type="checkbox"/> PRACTICE	<input type="checkbox"/> PITS (Infield) (Outside)	<input type="checkbox"/> BEING PASSED
<input type="checkbox"/> TIME TRIALS	<input type="checkbox"/> PIT ENTRANCE (Infield) (Outside)	<input type="checkbox"/> SUDDEN MECH. FAILURE
<input type="checkbox"/> HEAT	<input type="checkbox"/> TURN#	<input type="checkbox"/> NORMAL RACING
<input type="checkbox"/> PIT STOP	<input type="checkbox"/> STRAIGHTAWAY	<input type="checkbox"/> MAINTENANCE (Fuel) (Tires) (Mechanical)
<input type="checkbox"/> YELLOW FLAG	<input type="checkbox"/> FENCE: (CC) (Wheel)	<input type="checkbox"/> LOADING
<input type="checkbox"/> DURING RACE: (Start) (Early) (Mid) (Late) (Finish)	<input type="checkbox"/> GRANDSTAND: (Seats) (Steps) (Row #: (Low) (Mid) (Upper)	<input type="checkbox"/> UNLOADING
<input type="checkbox"/> BETWEEN RACES	<input type="checkbox"/> INFIELD (Parking) (Seating)	<input type="checkbox"/> HORSEPLAY
<input type="checkbox"/> AFTER RACES	<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER:

SITUATION:	SURFACE:	CONDITION:	WITNESSES"
IF MECHANICAL FAILURE:	<input type="checkbox"/> ASPHALT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOST FRONT WHEEL (L) (R)	<input type="checkbox"/> DIRT	<input type="checkbox"/> WET	* If yes, use reverse side of this form to record name, phone, address
<input type="checkbox"/> LOST REAR WHEEL (L) (R)	<input type="checkbox"/> MUD	<input type="checkbox"/> SNOW/ICE	
<input type="checkbox"/> CUT TIRE	<input type="checkbox"/> ICE	<input type="checkbox"/> IRREGULAR	
<input type="checkbox"/> BLOWN ENGINE	<input type="checkbox"/> CONCRETE	<input type="checkbox"/> OILY	
<input type="checkbox"/> STUCK THROTTLE	<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER	
<input type="checkbox"/> OTHER:			
IF NON-MECHANICAL:	DESCRIBE HOW ACCIDENT HAPPENED:		
<input type="checkbox"/> HIT MULTIPLE CAR PILE-UP	(Over for witness information)		
<input type="checkbox"/> COLLIDED W/ _____			
<input type="checkbox"/> HIT BY _____			
<input type="checkbox"/> FALL (Slip) (Trip) (Pushed)	(Print)	(Title)	
<input type="checkbox"/> Other:	Completed by:	Phone:	

COMPLETE AND RETURN TO JONES BROWN INC.