



MOTORCYCLING NEW ZEALAND INC

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Postal: PO Box 253; Huntly 3740 - Courier: 211 Main Street; Huntly 3700

EVENT INJURY REPORT

Date of Event _____ Permit No. _____ Stewards Name _____ Organising Club _____

Name of Injured Person	DOB	Licence #	Racing Stopped	Obvious Injury	Concussion Risk	Referred to	Transported By
Rider <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Other <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> SUSPECTED <input type="checkbox"/> NO <input type="checkbox"/>		Private Car <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Other <input type="checkbox"/>

DESCRIPTION OF INJURIES:

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Rider <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Other <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> SUSPECTED <input type="checkbox"/> NO <input type="checkbox"/>		Private Car <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Other <input type="checkbox"/>

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ATTENTION STEWARDS: This form must be given to the Medical Personnel at the start of the event. After the event this form must be sent to the MNZ Office with the Stewards Report & injured competitors licence & logbook (as per rule 6.2 & 6.2a).

Name of Medical Person: _____
Position - St John Registered Nurse Doctor Private Medical Person