

LOG Report No. _____

Connecting Report No. _____



STATE OF COLORADO LAND INCIDENT REPORT

Per Arkansas Headwaters Recreation Area Special Activity Permit (6 c) In the event of an incident resulting in the death, disappearance or unconsciousness of Permittee, its authorized agents or clients ("Critical Incident"), Permittee shall notify the State by telephone or e-mail as soon as practical, but no later than 24 hours after such incident, and submit a follow-up written report, e-mailed or faxed, within five calendar days of such incident.

In the event of any other incident resulting in Permittee, its authorized agents or clients receiving treatment by a physician or paramedic, Permittee shall notify the State by submitting a written report, e-mailed or faxed, within ten calendar days of such incident. Reports must be submitted electronically or mailed to 307 West Sackett Ave, Salida, CO 81201.

COMPANY _____
 (Company Name, no DBAs)

PRIMARY CONTACT _____

COMPLETE ALL BLOCKS (Indicate those not applicable by "NA", indicate unknown information by "Unk"). **USE FULL LEGAL NAMES** (Last name, first name, middle initial).

0	STAFF / GUIDE INFORMATION
OPERATOR (guide) NAME	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE DATE OF BIRTH
ADDRESS	
PHONE (Work and Home)	(Cell phone)

TL	TRIP LEADER
TRIP LEADER NAME	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE DATE OF BIRTH
ADDRESS	
PHONE (Work and Home)	(Cell phone)

If there are more than two victims, list the others on page 2.

V1	VICTIM INFORMATION
NAME	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE DATE OF BIRTH
ADDRESS	
PHONE (Work and Home)	(Cell phone)
NATURE OF INJURY	
MEDICAL TREATMENT	

V2	VICTIM INFORMATION
NAME	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE DATE OF BIRTH
ADDRESS	
PHONE (Work and Home)	(Cell phone)
NATURE OF INJURY	
MEDICAL TREATMENT	

If this accident resulted in a death or disappearance, what law enforcement agency did you immediately notify? NA

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Accident Data	DATE OF ACCIDENT	TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM	NAME OF BODY OF WATER		
	NEAREST CITY OR TOWN	COUNTY		EXACT LOCATION OF ACCIDENT		
	WEATHER	CLASS OF WATER		CONDITIONS	WIND	VISIBILITY
<input type="checkbox"/> Clear	<input type="checkbox"/> Fog	<input type="checkbox"/> I One	<input type="checkbox"/> IV Four	Air Temp. _____	<input type="checkbox"/> None	<input type="checkbox"/> Good
<input type="checkbox"/> Cloudy	<input type="checkbox"/> Rain	<input type="checkbox"/> II Two	<input type="checkbox"/> V Five		<input type="checkbox"/> Light (0-6 MPH)	<input type="checkbox"/> Fair
<input type="checkbox"/> Partly cloudy	<input type="checkbox"/> Snow	<input type="checkbox"/> III Three	<input type="checkbox"/> VI Six		<input type="checkbox"/> Moderate (7-14 MPH)	<input type="checkbox"/> Poor
					<input type="checkbox"/> Strong (15-25 MPH)	
					<input type="checkbox"/> Storm (Over 25 MPH)	

If there are more than two victims, list below and check VICTIM to indicate. If there were more than four witnesses, add additional pages as needed.

W1 <input type="checkbox"/> WITNESS <input type="checkbox"/> VICTIM		W2 <input type="checkbox"/> WITNESS <input type="checkbox"/> VICTIM	
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
ADDRESS		ADDRESS	
PHONE (Work and Home)	(Cell phone)	PHONE (Work and Home)	(Cell phone)
LOCATION		LOCATION	
W3 <input type="checkbox"/> WITNESS <input type="checkbox"/> VICTIM		W4 <input type="checkbox"/> WITNESS <input type="checkbox"/> VICTIM	
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
ADDRESS		ADDRESS	
PHONE (Work and Home)	(Cell phone)	PHONE (Work and Home)	(Cell phone)
LOCATION		LOCATION	

ACCIDENT DESCRIPTION

Sequence of events, rescue procedures, first aid rendered, etc. (Attach diagram or additional sheets if necessary).

PERSON COMPLETING REPORT

NAME	DATE OF BIRTH
ADDRESS	JOB TITLE
PHONE (Work and Home)	(Cell Phone) E-MAIL
<input type="checkbox"/> Vessel Owner <input type="checkbox"/> N/A <input type="checkbox"/> Operator (Guide) <input type="checkbox"/> Other Trip Leader <input type="checkbox"/> Outfitter	<input type="checkbox"/> I AFFIRM THIS INFORMATION IS TRUE AND CORRECT SIGNATURE DATE

FOR REVIEWING AUTHORITY ONLY

PRIMARY CAUSE	SECONDARY CAUSE
TYPE OF ACCIDENT	CAUSES BASED ON <input type="checkbox"/> THIS REPORT <input type="checkbox"/> INVESTIGATION <input type="checkbox"/> REPORT AND INVESTIGATION <input type="checkbox"/> COULDN'T BE DETERMINED
RECEIVED BY	DATE RECEIVED