






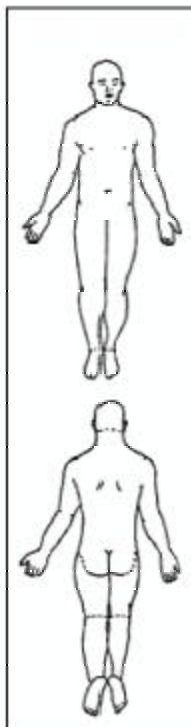
 Chirurgeon Incident Report 		
Date:	SCA Name:	Branch:
Legal Name:		
Address:		
Date of Birth:	Phone #:	
Complaint:		
Treatment:		
Attending Chirurgeon(s):		
Injury Type: <input type="checkbox"/> Heavy <input type="checkbox"/> Rapier <input type="checkbox"/> Bystander <input type="checkbox"/> Kitchen <input type="checkbox"/> Dancing <input type="checkbox"/> Camping <input type="checkbox"/> Other:		
Signature of Release:		
<input type="checkbox"/> Witness / <input type="checkbox"/> Parent:		

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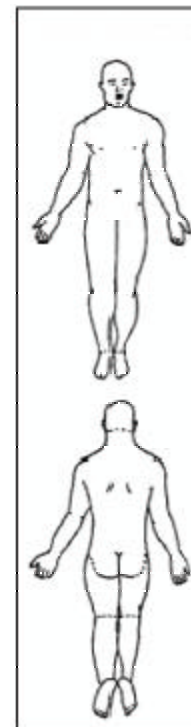
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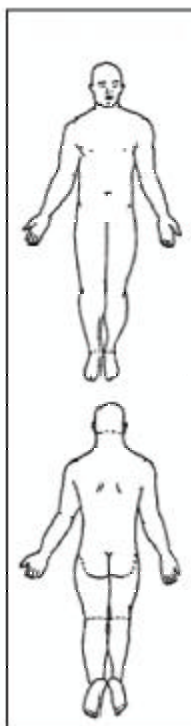
Additional Information:



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