

WEST VIRGINIA DIVISION OF NATURAL RESOURCES
WHITEWATER RAFTING INJURY REPORT aka MB-3 REPORT (To be submitted within 15 days of injury)

Company: _____

Date of Injury/Accident: ____ / ____ / ____

Time of Injury/Accident: ____:____ A.M. / P.M.

Injured Person: _____

Sex: [] M [] F Age: _____

Address: _____ City: _____ State: _____ Phone: _____ - _____ - _____

Rafting Experience: [] No [] Yes Times: _____ Rivers: _____

Wearing Wetsuit: [] No [] Yes Helmet: [] No [] Yes PFD: [] No [] Yes Type: _____

River Segment: [] Upper Gauley [] Upper New [] Cheat Canyon [] Shenandoah
[] Lower Gauley [] Lower New [] Cheat Narrows [] Tygart [] Other _____

River Location (Rapid name, etc.): _____

Weather Condition: [] Sunny [] Cloudy [] Light Rain [] Rain [] Thunderstorms

River Conditions: Water Level: _____ cfs Water Temperature _____°F Air Temperature: _____°F

ACCIDENT DESCRIPTION: Injury Occurred: [] During a Swim [] In a Raft/Boat [] On Shore [] During Rescue [] Other _____

Injured Party's Description: _____

More on Page 2? []

[] Refused First Aid Signature of Injured: _____

Witnesses: _____

Trip Leader's / Guide's Description: _____

More on Page 2? []

Trip Leader: _____ Guide: _____

Safety Orientation by: _____

Possible: [] Fatality [] Concussion Injury [] Left [] Upper Leg [] Chest [] Thumb
Injury: [] Sprain/Strain [] Dislocation Zone: [] Right [] Knee [] Back [] Head
[] Contusion/Bruise [] Fracture [] Both [] Lower Leg [] Neck [] Face
[] Abrasion [] Laceration/Puncture [] Multiple [] Ankl [] Shoulder [] Eye
[] Hypothermia [] Heat Stroke/ Exhaustion [] Foot [] Arm [] Nose
[] Illness _____ [] Hip [] Wrist [] Mouth
[] Other _____ [] Abdomen [] Hand [] Teeth
[] Other

Action Taken:

First Aid: [] None [] CPR [] Direct Pressure [] Antiseptic [] Elevated Injury
[] Bandage [] Splint/Immobilize [] Ice [] Treated Shock [] Other _____
[] Recommended additional medical diagnosis [] Injured sought additional medical diagnosis
[] Injured intends to seek additional medical diagnosis Where _____

Evacuated: [] No [] Yes Injured Taken to: [] Hospital [] Base Camp [] Other _____

Admitted to Hospital: [] No [] Yes Name of Hospital _____

Evaluated by: [] Hospital Medical Professional Staff
[] Other _____

Treatment: [] Diagnosis Only [] Stitches [] Splint or Cast [] Medication
[] Surgery [] Oxygen [] Other _____

* If treatment, other than diagnosis was rendered, this form must be submitted to WVDNR within 15 days of the date of Injury *

Signature of Person Completing Form _____ Date: ____ / ____ / ____

Injured Person's Description (Continued)

Trip Leader's Description (Continued)
