



SKYRUNNING ACCIDENT INSURANCE CLAIM FORM

Race data:

Event name: _____

Event date: ____ / ____ / ____

Location: _____ Country: _____

Athlete's data:

Name: _____ Surname: _____

Date of birth: ____ / ____ / ____

Residence address: _____

Phone: + _____ Email: _____

Accident details:

Date of the accident: ____ / ____ / ____

Description of the accident: _____

Injury suffered: _____

Race marshalls/volunteers/doctors/athletes who attended the accident:

*NB Please provide athletes@skyrunning.com with all the medical documentation to evaluate the injury.