Please place your cursor in any of the fields and begin typing your responses. Use your mouse to click on any text boxes. Once completed, you may click on the buttons at the end of the form to print the incident report from your computer or clear all responses.

American Specialty Insurance Services, Inc.
ATTN: Claims Department
142 N. Main Street, P.O. Box 459
Roanoke, IN 46783-0309
Phone: (800) 566-7941 Fax: (260) 673-1291

FIRST REPORT OF ACCIDENT

DATE OF INCIDENT_____ TIME OF INCIDENT_____AM/PM

Name of Team or League:_____

Name of Event:_____

Fieldowner/Location of Event:_____

Address:_____

DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? ☐ **YES** ☐ **NO**

If yes, please provide name of company and policy #:_____

_____

State / location in which injury occurred: _____

Telephone Number: (_____)_____

INJURED PERSON: ☐ Athlete ☐ Official ☐ Coach ☐ Spectator ☐ Employee ☐ Volunteer ☐ Other _____

DID THIS TAKE PLACE DURING:

☐ Practice ☐ Competition ☐ Club activity
☐ Pre-activity ☐ Sanctioned event ☐ During activity
☐ After activity ☐ While traveling

INJURED PERSON INFORMATION

Last Name	**First**	**Middle**	**Telephone Number ( )** ☐ **Single** ☐ **Married**
Address			**Social Security Number**
City	**State**	**Zip**	**Employer and Address**
Age	**D.O.B.**	☐ **Male** ☐ **Female**	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name	**First**	**Middle**	**Telephone Number ( )**
Address	**City**	**State**	**Zip**
Last Name	**First**	**Middle**	**Telephone Number ( )**
Address	**City**	**State**	**Zip**

INCIDENT LOCATION

☐ Competition area ☐ Concession area
☐ Parking lot ☐ Admission area
☐ Restrooms/locker rooms ☐ Off property
☐ Premises/grounds ☐ Store area
☐ Bleachers/stands

CLASSIFICATION

☐ Non-injury ☐ Minor injury or illness
☐ Serious injury or illness

PRIMARY INJURY

☐ Allergy ☐ Dislocation ☐ Nausea
☐ Amputation ☐ Electrical Shock ☐ Stroke
☐ Abrasion ☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture ☐ Death
☐ Drowning ☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Cardiac ☐ Illness
☐ Cold Injury ☐ Contusion ☐ Sting/bite
☐ Seizures ☐ Concussion
☐ Strain/Sprain ☐ Tooth/Mouth

BODY PART INJURED

☐ Eye (L/R) ☐ Torso ☐ Arm (L/R)
☐ Nose ☐ Back ☐ Tooth
☐ Neck ☐ Face ☐ Head
☐ Ear (L/R) ☐ Leg (L/R) ☐ Wrist (L/R)
☐ Knee (L/R) ☐ Ankle (L/R) ☐ Finger or Toe
☐ Internal ☐ Hip (L/R) ☐ Hand (L/R)
☐ Shoulder (L/R) ☐ Foot (L/R) ☐ Elbow (L/R)

DISPOSITION

☐ Released to parent ☐ Police
☐ Refusal of care ☐ Ambulance
☐ Refer to doctor ☐ Report only
☐ Refer to hospital or clinic ☐ Medical attention
☐ EMS transport ☐ Patient requested EMS transport
☐ Released to personal vehicle ☐ Patient requested EMS transport

Describe how the incident occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		( )
2.		( )

Signature of Coach or Official (with no relationship to claimant) _____ **DATE**_____ **Phone #**_____

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