FIRST REPORT OF ACCIDENT

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
ATTN: CLAIMS DEPARTMENT
POST OFFICE BOX 459
ROANOKE, IN 46783
PHONE: 800-566-7941 FAX: 260-673-1291
EMAIL: AMERSPEC@AMERSPEC.COM

DATE OF INCIDENT_____ **TIME** _____ ☐**AM** ☐**PM**

Team/Club/Organization:_____

Address:_____

Telephone Number:_____

DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE?

☐Yes ☐ No If so, please provide:

Name of Company:_____

Policy #:_____

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

_____

DID THIS TAKE PLACE DURING: ☐ Practice ☐ Pre-Game ☐ During Game ☐ Post-Game ☐ While Traveling ☐ Other _____

INJURED PERSON INFORMATION

Last Name First Middle

Telephone Number ( ) ☐Single ☐Married

Address

City State Zip

Age D.O.B. ☐Male ☐Female

Social Security Number:_____

Employer Name:_____

Address:_____

_____

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name First Middle

Telephone Number ( )

Address City State Zip

INCIDENT LOCATION

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

INCIDENT

☐Assault/Sexual ☐Slip/bodily reaction
☐Assault/Non-Sexual ☐Slip/Fall
☐Fall (different level) ☐Aquatic
☐Caught in/on/between ☐Overexertion
☐Collision (with object) ☐Animal/insect bite/ sting
☐Struck by falling/flying object
☐Collision (participant/participant)
☐Collision (participant/spectator)
☐Collision (spectator/spectator)

PRIMARY INJURY

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

BODY PART INJURED

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

DISPOSITION

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

CLASSIFICATION

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

DESCRIBE HOW THE INCIDENT OCCURRED: ***(attach a separate sheet if necessary)***

WITNESS INFORMATION

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

SIGNATURE OF PERSON COMPLETING FORM: _____ **DATE** _____

PRINTED NAME:_____ **PHONE:** _____

#1823053