

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 _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Team/Club/Organization: _____ Address: _____ Telephone Number: _____		DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide: Name of Company: _____ Policy #: _____	
INJURED PERSON: <input type="checkbox"/> Athlete <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ _____		DID THIS TAKE PLACE DURING: <input type="checkbox"/> Practice <input type="checkbox"/> Pre-Game <input type="checkbox"/> During Game <input type="checkbox"/> Post-Game <input type="checkbox"/> While Traveling <input type="checkbox"/> Other _____	
INJURED PERSON INFORMATION			
Last Name _____ First _____ Middle _____		Telephone Number () _____	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address _____		Social Security Number: _____	
City _____ State _____ Zip _____		Employer Name: _____	
Age _____	D.O.B. _____	Address: _____	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)			
Last Name _____ First _____ Middle _____		Telephone Number () _____	
Address _____		City _____ State _____ Zip _____	
INCIDENT LOCATION		INCIDENT	
<input type="checkbox"/> Competition area	<input type="checkbox"/> Concession area	<input type="checkbox"/> Assault/Sexual	<input type="checkbox"/> Slip/bodily reaction
<input type="checkbox"/> Parking lot	<input type="checkbox"/> Admission area	<input type="checkbox"/> Assault/Non-Sexual	<input type="checkbox"/> Slip/Fall
<input type="checkbox"/> Restrooms	<input type="checkbox"/> Off property	<input type="checkbox"/> Fall (different level)	<input type="checkbox"/> Aquatic
<input type="checkbox"/> Locker rooms	<input type="checkbox"/> Store area	<input type="checkbox"/> Caught in/on/between	<input type="checkbox"/> Overexertion
<input type="checkbox"/> Premises/grounds		<input type="checkbox"/> Collision (with object)	<input type="checkbox"/> Animal/insect bite/ sting
<input type="checkbox"/> Bleachers/stands		<input type="checkbox"/> Struck by falling/flying object	
		<input type="checkbox"/> Collision (participant/participant)	
		<input type="checkbox"/> Collision (participant/spectator)	
		<input type="checkbox"/> Collision (spectator/spectator)	
PRIMARY INJURY		CLASSIFICATION	
<input type="checkbox"/> Allergy	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Nausea	
<input type="checkbox"/> Amputation	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Burn	
<input type="checkbox"/> Laceration	<input type="checkbox"/> Fracture	<input type="checkbox"/> Death	
<input type="checkbox"/> Drowning	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Pain	
<input type="checkbox"/> Sting/bite	<input type="checkbox"/> Contusion	<input type="checkbox"/> Illness	
<input type="checkbox"/> Cold Injury	<input type="checkbox"/> Concussion	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tooth/Mouth		
<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Electric Shock		
BODY PART INJURED		DISPOSITION	
<input type="checkbox"/> Eye - L or R	<input type="checkbox"/> Torso	<input type="checkbox"/> Arm - L or R	<input type="checkbox"/> Released to parent
<input type="checkbox"/> Nose	<input type="checkbox"/> Back	<input type="checkbox"/> Tooth	<input type="checkbox"/> Refusal of care
<input type="checkbox"/> Neck	<input type="checkbox"/> Face	<input type="checkbox"/> Head	<input type="checkbox"/> Police
<input type="checkbox"/> Ear - L or R	<input type="checkbox"/> Leg - L or R		<input type="checkbox"/> Ambulance
<input type="checkbox"/> Knee - L or R	<input type="checkbox"/> Ankle - L or R		<input type="checkbox"/> Report only
<input type="checkbox"/> Internal	<input type="checkbox"/> Hip - L or R		
<input type="checkbox"/> Shoulder - L or R	<input type="checkbox"/> Foot - L or R		
<input type="checkbox"/> Elbow - L or R	<input type="checkbox"/> Hand - L or R		
<input type="checkbox"/> Wrist - L or R	<input type="checkbox"/> Finger or Toe		
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:** _____