AMERICANSPECIALTYEXPRESS.COM
FIRST REPORT OF ACCIDENT

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. JEFFERSON BLVD., SUITE 150
FORT WAYNE, IN 46804-4133
PHONE: 800.566.7941 FAX: 260.969.4729
email: claims@americanspecialty.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			Social Security Number: ______	
City	State	Zip	Employer Name: ______	
Age	D.O.B.	☐ Male ☐ Female	Address: ______	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

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

INCIDENT LOCATION

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

INCIDENT

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

PRIMARY INJURY

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

BODY PART INJURED

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

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:** ________