AMERICAN SPECIALTY
FIRST REPORT OF ACCIDENT

DATE OF INCIDENT_____ TIME _____ ☐AM ☐PM

Association/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:_____

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

INCIDENT LOCATION	INCIDENT	PRIMARY INJURY
☐Competition area ☐Concession area	☐Assault/Sexual ☐Slip/bodily reaction	☐Allergy ☐Dislocation ☐Nausea
☐Parking lot ☐Admission area	☐Assault/Non-Sexual ☐Slip/Fall	☐Amputation ☐Cardiac ☐Stroke
☐Restrooms ☐Off property	☐Fall (different level) ☐Aquatic	☐Abrasion ☐Foreign Body ☐Burn
☐Locker rooms ☐Store area	☐Caught in/on/between ☐Overexertion	☐Laceration ☐Fracture ☐Death
☐Premises/grounds	☐Collision (with object) ☐Animal/insect bite/sting	☐Drowning ☐Cardiac ☐Pain
☐Bleachers/stands	☐Struck by falling/flying object	☐Sting/bite ☐Contusion ☐Illness
	☐Collision (participant/participant)	☐Cold Injury ☐Concussion ☐Seizures
	☐Collision (participant/spectator)	☐Hypertension ☐Tooth/Mouth
	☐Collision (spectator/spectator)	☐Strain/Sprain ☐Electric Shock

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BODY PART INJURED	DISPOSITION		CLASSIFICATION
☐Eye - L or R ☐Torso ☐Arm - L or R	☐Released to parent	☐Police	☐Non-Injury
☐Nose ☐Back ☐Tooth	☐Refusal of care	☐Ambulance	☐Minor injury or illness
☐Neck ☐Face ☐Head	☐Refer to doctor	☐Report only	☐Serious injury or illness
☐Ear - L or R ☐Leg - L or R	☐Refer to hospital or clinic		
☐Knee - L or R ☐Ankle - L or R	☐Medical attention		
☐Internal ☐Hip - L or R	☐EMS transport		
☐Shoulder - L or R ☐Foot - L or R	☐Patient requested EMS transport		
☐Elbow - L or R ☐Hand - L or R	☐Released to personal vehicle		
☐Wrist - L or R ☐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: _____