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

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
☐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:** ____________