



American Specialty Insurance Services, Inc.  
 ATTN: Claims Department  
 142 N. Main Street, P.O. Box 459  
 Roanoke, IN 46783-0309  
 Phone: (800) 566-7941 Fax: (260) 673-1291

**AASA FIRST REPORT OF ACCIDENT**

<b>DATE OF INCIDENT</b> _____ <b>TIME OF INCIDENT</b> _____ AM/PM Name of Team/Club/Organization: _____ Address: _____ Telephone Number: _____	<b>DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide name of company and policy #: _____
<b>INJURED PERSON:</b> <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 _____	<b>DID THIS TAKE PLACE DURING:</b> <input type="checkbox"/> Practice <input type="checkbox"/> Competition <input type="checkbox"/> Club activity <input type="checkbox"/> Pre-activity <input type="checkbox"/> Sanctioned event <input type="checkbox"/> During activity <input type="checkbox"/> After activity <input type="checkbox"/> While traveling

**INJURED PERSON INFORMATION**

<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number ( )</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married
<b>Address</b>			<b>Social Security Number</b>	
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Employer and Address</b>	
<b>Age</b>	<b>D.O.B.</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		

**GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)**

<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number ( )</b>	
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	

<b>SPORT</b> <input type="checkbox"/> Martial Arts <input type="checkbox"/> Paintball <input type="checkbox"/> Baseball <input type="checkbox"/> Gymnastics <input type="checkbox"/> Football <input type="checkbox"/> Volleyball <input type="checkbox"/> Basketball <input type="checkbox"/> Other _____	<b>INCIDENT LOCATION</b> <input type="checkbox"/> Competition area <input type="checkbox"/> Concession area <input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area <input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property <input type="checkbox"/> Premises/grounds <input type="checkbox"/> Store area <input type="checkbox"/> Bleachers/stands  <b>CLASSIFICATION</b> <input type="checkbox"/> Non-injury <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Serious injury or illness	<b>INCIDENT</b> <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Aquatic <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Trip/Fall <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Overexertion <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Struck by falling/flying object
<b>PRIMARY INJURY</b> <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea <input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <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"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth	<b>BODY PART INJURED</b> <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe	<b>DISPOSITION</b> <input type="checkbox"/> Released to parent <input type="checkbox"/> Police <input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report only <input type="checkbox"/> Refer to hospital or clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle

**Describe how the incident occurred: (attach a separate sheet if necessary)**

**WITNESS INFORMATION**

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

**Signature of Coach or Official (with no relationship to claimant)** \_\_\_\_\_ **DATE** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
 AmerSpec-140341(11-02)