



SPECIAL OLYMPICS

FIRST REPORT OF ACCIDENT / INCIDENT



U.S. Program/Area: Date of Incident: _____

Injured Person/Party Information

Date of Birth: ___/___/___ Age: _____
Name: _____
(Last) (First) (MI)
Address: _____
(Street) (City) (State) (Zip)
Home Phone: (____)____-____ Work Phone: (____)____-____
Gender: Male Female Social Security Number: _____-____-____

Type of Injury/ Accident:

- Bodily Injury
- Property Damage
- Automobile
- Other: _____

Injured Party:

- Athlete
- Volunteer
- Coach
- Employee
- Spectator
- Unified Partner
- Property Owner
- Other: _____

Description of Accident (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____

Site / event where accident occurred: _____

ACCIDENT OCCURRED DURING:

- Training/Practice
- Competition
- Traveling to or from SO event
- Other: _____

TYPE OF INJURY:

- Severe cut w/ bleeding
- Less serious bruise or cut
- Break/fracture
- Concussion
- Paralysis
- Fatality
- Other: _____

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
- Other: _____

SPORT

- Alpine Skiing
- Aquatics
- Athletics
- Badminton
- Baseball
- Basketball
- Bocce
- Bowling
- Cheerleading
- Cross Country Ski
- Cycling
- Equestrian
- Figure Skating
- Floor Hockey
- Golf
- Gymnastics
- Kickball
- Power Lifting
- Relay Game
- Roller Skating
- Sailing
- Snowboarding
- Snowshoe
- Soccer
- Softball
- Speed Skating
- Swimming
- Table Tennis
- Team Handball
- Tennis
- Track & Field
- Volleyball
- Other: _____

BODY PART INJURED:

- Head
- Neck
- Torso
- Back
- Hand (L / R)
- Finger (L / R)
- Elbow (L / R)
- Shoulder (L / R)
- Leg (L / R)
- Knee (L / R)
- Thigh (L / R)
- Shin (L / R)
- Toe (L / R)
- Other: _____

Contact/Care Provider Information If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____
Name: _____
Address: _____
Home Phone: (____)____-____

Employer Name: _____
Employer Address: _____
Work Phone: (____)____-____

Does the injured person have medical insurance? Yes No
If yes, insurance is provided by: Injured Person Care Provider/Responsible Party
Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ Daytime Phone: (____)____-____
Witness #2 Name: _____ Daytime Phone: (____)____-____

Special Olympics Official / Representative (other than claimant)

Name: _____ Daytime Phone: (____)____-____
Signature: _____

SEND COMPLETED FORM TO:
AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. Jefferson Blvd, Suite 150
Fort Wayne, Indiana 46804-4133
Fax: 260.969.4729

IF INJURY WAS SERIOUS OR A FATALITY:
IMMEDIATELY NOTIFY AMERICAN SPECIALTY
AT 800.566.7941, 24 hours a day/7 days a week