



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: _Personal time.

Type of Injury:

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

Name: _____ Employer Address: _____

Address: _____

Home Phone: (____) _____ - _____ 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 Services, Inc., 7609 W. Jefferson Blvd. Suite 100, Fort Wayne, IN 46804-4133; Fax: 260.969.4729

AND one copy to

Special Olympics Pennsylvania, 2570 Blvd. of the Generals, Suite 124, Norristown, PA 19403 or Fax: (610) 630-9456

If injury was serious or a fatality: IMMEDIATELY notify American Specialty Insurance Services, Inc.

Telephone: (800) 566-7941 (24 hours a day / 7 days a week)

AMER: 150525 - SpecOlym Inc. Rep. Form 02-03