

**ALLIANCE MANAGEMENT GROUP 2016  
STATE SOCCER ASSOCIATIONS OF IOWA,  
KANSAS AND NEBRASKA**

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.  
7609 W. JEFFERSON BLVD., SUITE 150  
FORT WAYNE, INDIANA 46804-4133  
PHONE: 800.566.7941 | FAX: 260.969.4729



**FIRST REPORT OF ACCIDENT**

DATE OF INCIDENT:	TIME OF INCIDENT:	AM/PM	DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide policy #: _____
NAME OF TEAM/CLUB/ORGANIZATION:			Insurance Company Name: _____
ADDRESS:			DID THIS TAKE PLACE DURING: <input type="checkbox"/> Practice <input type="checkbox"/> Pre-Activity <input type="checkbox"/> Competition <input type="checkbox"/> Post Activity <input type="checkbox"/> While Traveling <input type="checkbox"/> Other:
TELEPHONE NUMBER:			
LOCATION OF INCIDENT:			
ADDRESS OF INCIDENT:			
INJURED PERSON: <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:			

**INJURED PERSON INFORMATION:**

LAST NAME	FIRST	MIDDLE
ADDRESS		
CITY	STATE	ZIP
PHONE #		
SOCIAL SECURITY #	AGE	D.O.B. / /
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
EMPLOYER INFORMATION: NAME _____		
ADDRESS _____		
CITY		STATE ZIP

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

LAST NAME	FIRST	MIDDLE	PHONE #
ADDRESS			STATE ZIP

INCIDENT LOCATION		INCIDENT		PRIMARY INJURY		
<input type="checkbox"/> Outdoor <input type="checkbox"/> Indoor <input type="checkbox"/> Off Property	<input type="checkbox"/> Competition Area <input type="checkbox"/> Parking Lot <input type="checkbox"/> Premises/Grounds <input type="checkbox"/> Bleachers/Stands <input type="checkbox"/> Concession Area <input type="checkbox"/> Restrooms/Locker Rooms	<input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Animal/insect bite/sting <input type="checkbox"/> Collision (with object)	<input type="checkbox"/> Slip/bodily reaction <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Aquatic <input type="checkbox"/> Trip/Fall <input type="checkbox"/> Overexertion	<input type="checkbox"/> Allergy <input type="checkbox"/> Amputation <input type="checkbox"/> Abrasion <input type="checkbox"/> Laceration <input type="checkbox"/> Drowning <input type="checkbox"/> Hypertension <input type="checkbox"/> Cold Injury <input type="checkbox"/> Seizures <input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Dislocation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Sting/Bite <input type="checkbox"/> Foreign Body <input type="checkbox"/> Concussion <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Cardiac <input type="checkbox"/> Contusion <input type="checkbox"/> Tooth/Mouth	<input type="checkbox"/> Nausea <input type="checkbox"/> Stroke <input type="checkbox"/> Burn <input type="checkbox"/> Death <input type="checkbox"/> Pain <input type="checkbox"/> Illness <input type="checkbox"/> Fracture
SURFACE		DISPOSITION		CLASSIFICATION		
<input type="checkbox"/> Natural grass <input type="checkbox"/> Concrete	<input type="checkbox"/> Synthetic turf <input type="checkbox"/> Other	<input type="checkbox"/> Released to parent <input type="checkbox"/> Refusal of care <input type="checkbox"/> Refer to doctor <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	<input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Report only	<input type="checkbox"/> Non-injury <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Serious injury or illness		
BODY PART INJURED		DISPOSITION		CLASSIFICATION		
<input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Finger or Toe (L/R)	<input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Nose <input type="checkbox"/> Tooth <input type="checkbox"/> Neck	<input type="checkbox"/> Released to parent <input type="checkbox"/> Refusal of care <input type="checkbox"/> Refer to doctor <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	<input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Report only	<input type="checkbox"/> Non-injury <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> 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 Coach or Official (with no relationship to claimant): \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_