



# SPECIAL OLYMPICS

## FIRST REPORT OF ACCIDENT / INCIDENT



U.S. Program/Area: Special Olympics Montana 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  
 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  
 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: \_\_\_\_\_  
Please provide name of Company and Policy Number: \_\_\_\_\_

Injured Person  Care Provider/Responsible Party

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

Witness #1 Name: \_\_\_\_\_  
Witness #2 Name: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Daytime Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Special Olympics Official / Representative (other than claimant)

Name: \_\_\_\_\_  
Signature: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Send completed form to:  
If injury was serious or a fatality:

American Specialty Insurance Services, Inc., P.O. Box 459, Roanoke, IN 46783-0309; Fax: (260) 673-1291  
IMMEDIATELY notify American Specialty Insurance Services, Inc.  
Telephone: (800) 566-7941 (24 hours a day / 7 days a week)