



# INCIDENT REPORT FORM FOR BODILY INJURY

American Specialty Insurance & Risk Services, Inc.  
Attn: Claims Department  
Post Office Box 459  
Roanoke, IN 46783  
Phone: 800-566-7941 Fax: 260-672-8835



<b>Date of Incident:</b> _____ <b>Time of Incident:</b> _____ AM / PM If injured person is a League member, identify: <b>League Club Name:</b> _____ <b>Club Address:</b> _____	<b>Does the Injured Person Have Other Medical Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: <b>Name of company:</b> _____ <b>Policy #:</b> _____
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<b>Injured Person:</b> <input type="checkbox"/> Club Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Participant <input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____  Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No  Was the injured person riding: <input type="checkbox"/> Tandem Bike <input type="checkbox"/> Single Bike	<b>Did This Take Place During:</b> <input type="checkbox"/> Club Ride <input type="checkbox"/> Special Event <input type="checkbox"/> Time Trial <input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event <input type="checkbox"/> Fundraiser If during a Special Event, list name of event: _____  Name of League Club putting on the Special Event: _____
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INJURED PERSON INFORMATION			
Last Name	First	Mid.	Telephone Number ( ) <input type="checkbox"/> Single <input type="checkbox"/> Married
Address			Social Security Number (optional):
City			Employer Name:
Age	D.O.B.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employer Address:
GUARDIAN/PARENT (if injured person is a minor)			
Last Name	First	Mid.	Telephone Number ( )
Address		City	State Zip

**SUSPECTED PRE-EXISTING CONDITION:**  Yes  No

<b>INCIDENT LOCATION</b> <input type="checkbox"/> Off Road <input type="checkbox"/> City Street <input type="checkbox"/> Parking Lot <input type="checkbox"/> Highway <input type="checkbox"/> Registration Area <input type="checkbox"/> Rural Road <input type="checkbox"/> Restrooms/Locker Rooms <input type="checkbox"/> Off Property <input type="checkbox"/> Premises/Grounds <input type="checkbox"/> Rest Stop	<b>INCIDENT</b> <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Overexertion <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Eligibility <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Trip/fall <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Slip/fall <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Animal/Insect Bite/Sting <input type="checkbox"/> Chased by dog <input type="checkbox"/> Collision (with parked car) <input type="checkbox"/> Bit by dog <input type="checkbox"/> Collision (with moving car) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (with object/animal)  <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Struck by falling/flying object	<b>WEATHER CONDITIONS</b> <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy
<b>RIDER ACTIVITY</b> <input type="checkbox"/> Turning right <input type="checkbox"/> Passing <input type="checkbox"/> Turning left <input type="checkbox"/> Intersection <input type="checkbox"/> Being passed <input type="checkbox"/> Straight	<input type="checkbox"/> Auto/property (also complete reverse side of this form)	<b>ROAD CONDITIONS</b> <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy
<b>CLASSIFICATION</b> <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness		<b>ROAD TYPE</b> <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel

<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"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth	<b>BODY PARTY 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"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Continued riding <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Refer to hospital/clinic
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**DESCRIBE HOW THE INCIDENT OCCURRED:**

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

Signature of Ride Leader or Official (with no relationship to claimant) \_\_\_\_\_  
 Date \_\_\_\_\_ Phone Number \_\_\_\_\_

