

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

<p>ACCIDENT OCCURRED DURING:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Training/Practice <input type="checkbox"/> Competition <input type="checkbox"/> Traveling to or from SO event <input type="checkbox"/> Other: _____ <p>TYPE OF INJURY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe cut w/ bleeding <input type="checkbox"/> Less serious bruise or cut <input type="checkbox"/> Break/fracture <input type="checkbox"/> Concussion <input type="checkbox"/> Paralysis <input type="checkbox"/> Fatality <input type="checkbox"/> Other: _____ 	<p>DISPOSITION:</p> <ul style="list-style-type: none"> <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"/> Other: _____ 	<p>BODY PART INJURED:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Torso <input type="checkbox"/> Back <input type="checkbox"/> Hand (L / R) <input type="checkbox"/> Finger (L / R) <input type="checkbox"/> Elbow (L / R) <input type="checkbox"/> Shoulder (L / R) <input type="checkbox"/> Leg (L / R) <input type="checkbox"/> Knee (L / R) <input type="checkbox"/> Thigh (L / R) <input type="checkbox"/> Shin (L / R) <input type="checkbox"/> Toe (L / R) <input type="checkbox"/> Other: _____ 	<p>SPORT:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Aquatics <input type="checkbox"/> Athletics <input type="checkbox"/> Badminton <input type="checkbox"/> Baseball <input type="checkbox"/> Basketball <input type="checkbox"/> Bocce <input type="checkbox"/> Bowling <input type="checkbox"/> Cheerleading <input type="checkbox"/> Cross Country Ski <input type="checkbox"/> Cycling <input type="checkbox"/> Equestrian <input type="checkbox"/> Figure Skating <input type="checkbox"/> Floor Hockey <input type="checkbox"/> Golf <input type="checkbox"/> Gymnastics <input type="checkbox"/> Kickball 	<p>SPORT cont.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Power Lifting <input type="checkbox"/> Relay Game <input type="checkbox"/> Roller Skating <input type="checkbox"/> Sailing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Snowshoe <input type="checkbox"/> Soccer <input type="checkbox"/> Softball <input type="checkbox"/> Speed Skating <input type="checkbox"/> Swimming <input type="checkbox"/> Table Tennis <input type="checkbox"/> Team Handball <input type="checkbox"/> Tennis <input type="checkbox"/> Track & Field <input type="checkbox"/> Volleyball <input type="checkbox"/> Other: _____
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Contact/Care Provider Information If an athlete or underage volunteer was injured, please identify 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: _____

SUBMIT ACCIDENT MEDICAL CLAIMS TO:
HEALTH SPECIAL RISK, INC. (HSR)
HSR Plaza II, 4100 Medical Parkway, Carrollton, TX 75007
Toll Free: 800.328.1114 | Fax: 972.512.5820
Email: claims@hsri.com

**Also please submit to website@soill.org,
or fax 309-888-2570 to Special Olympics Illinois**

SUBMIT LIABILITY CLAIMS TO:
AMERICAN SPECIALTY INSURANCE
7609 W. Jefferson Blvd., Suite 150, Fort Wayne, IN 46804
Toll Free: 800.566.7941 | Fax: 260.969.4729
Email: claims@americanspecialty.com

**IF INJURY WAS SERIOUS OR FATAL, IMMEDIATELY NOTIFY
AMERICAN SPECIALTY at 800.566.7941.**
We provide 24/7 Emergency Claims Phone Coverage.