INCIDENT REPORT FORM
FOR BODILY INJURY

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

Date of Incident:_____ **Time of Incident:**_____ **AM / PM**
If injured person is a League member, identify:
League Club Name:_____
Club Address:_____

Does the Injured Person Have Other Medical Insurance? ☐Yes ☐No
If yes, please provide:
Name of company:_____
Policy #:_____

Injured Person: ☐ Club Member ☐ Non-Member ☐ Participant
☐ Volunteer ☐ Pedestrian ☐ Other_____

Was the injured person wearing a helmet at the time of the accident?
☐ Yes ☐ No

Was the injured person riding: ☐ Tandem Bike ☐ Single Bike

Did This Take Place During: ☐ Club Ride ☐ Special Event ☐ Time Trial
☐ Race ☐ Conditioning Event ☐ Fundraiser
If during a Special Event, list name of event:_____
_____
Name of League Club putting on the Special Event: _____
_____

INJURED PERSON INFORMATION

Last Name First Mid.	Telephone Number ( ) ☐ Single ☐ Married
Address	Social Security Number (optional):
City	Employer Name:
Age D.O.B. ☐ Male ☐ 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

INCIDENT LOCATION
☐ Off Road ☐ City Street
☐ Parking Lot ☐ Highway
☐ Registration Area ☐ Rural Road
☐ Restrooms/Locker Rooms ☐ Off Property
☐ Premises/Grounds ☐ Rest Stop

RIDER ACTIVITY
☐ Turning right ☐ Passing
☐ Turning left ☐ Intersection
☐ Being passed ☐ Straight

CLASSIFICATION
☐ Minor injury or illness ☐ Non-injury
☐ Serious injury or illness

INCIDENT
☐ Assault/Sexual ☐ Overexertion
☐ Assault/Non-Sexual ☐ Eligibility
☐ Fall (different level) ☐ Trip/fall
☐ Fall (same level) ☐ Slip/fall
☐ Caught in, on, between ☐ Slip, bodily reaction
☐ Animal/Insect Bite/Sting ☐ Chased by dog
☐ Collision (with parked car) ☐ Bit by dog
☐ Collision (with moving car) ☐ Collision (participant/ participant)
☐ Collision (with object/animal)
☐ Collision (participant/pedestrian)
☐ Struck by falling/flying object
☐ Auto/property (also complete reverse side of this form)

WEATHER CONDITIONS
☐ Sunny ☐ Raining
☐ Foggy ☐ Snowing
☐ Cloudy

ROAD CONDITIONS
☐ Wet ☐ Dry
☐ Icy

ROAD TYPE
☐ Paved ☐ Dirt
☐ Gravel

PRIMARY INJURY
☐ Allergy ☐ Dislocation ☐ Nausea
☐ Amputation ☐ Electrical Shock ☐ Stroke
☐ Abrasion ☐ Foreign Body ☐ Burn
☐ Laceration ☐ Fracture ☐ Death
☐ Drowning ☐ Heat Exhaustion ☐ Pain
☐ Hypertension ☐ Sting/bite ☐ Illness
☐ Cold Injury ☐ Contusion ☐ Cardiac
☐ Seizures ☐ Concussion
☐ Strain/Sprain ☐ Tooth/Mouth

BODY PARTY INJURED
☐ Eye (L/R) ☐ Torso ☐ Arm (L/R)
☐ Nose ☐ Back ☐ Tooth
☐ Neck ☐ Face ☐ Head
☐ Ear (L/R) ☐ Leg (L/R)
☐ Knee (L/R) ☐ Ankle (L/R)
☐ Internal ☐ Hip (L/R)
☐ Shoulder (L/R) ☐ Foot (L/R)
☐ Elbow (L/R) ☐ Hand (L/R)
☐ Wrist (L/R) ☐ Finger or Toe

DISPOSITION
☐ Released to parent ☐ Police
☐ Refusal of care ☐ Ambulance
☐ Refer to doctor ☐ Report Only
☐ Medical attention
☐ EMS transport
☐ Continued riding
☐ Patient requested EMS transport
☐ Released to personal vehicle
☐ Refer to hospital/clinic

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_____ Email:_____

Please provide the name/email address of the individual that will be responsible for verifying claim information in the event of an incident (if different from above).

NAME_____EMAIL:_____