AMERICAN SPECIALTY*

American Specialty Insurance Services, Inc.
ATTN: Claims Department
142 N. Main Street, P.O. Box 459
Roanoke, IN 46783-0309
Phone: (800) 566-7941 Fax: (260) 673-1291

USA WRESTLING LIABILITY INCIDENT REPORT

DATE OF ACCIDENT_____ **TIME OF ACCIDENT**_____ ☐ AM ☐ PM

INJURED:

Name of Injured Person:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ Work Phone: (_____) _____

USA Wrestling Card #:_____ Social Security #:_____

Gender: ☐ Male ☐ Female Date of Birth:_____/_____/_____

Injured Party is a: ☐ Athlete ☐ Coach ☐ Official ☐ Volunteer ☐ Spectator ☐ Employee ☐ Other_____

Nature of accident: ☐ Bodily injury ☐ Property damage ☐ Other_____

DISPOSITION:

☐ On Site Care ☐ Ambulance ☐ Auto to Hospital ☐ Walked away

Where did the accident take place:

☐ At a club practice (name & address of club):_____

☐ At an event (name & location of event):_____

☐ Other (describe):_____

Describe how accident happened (be specific/attach a separate sheet if necessary):_____

Name and address of doctor or place of medical provider:_____

Guardian/Parent (If Injured Person is a Minor)

Last Name First Middle

Telephone Number : ( )

Address City State Zip

PRIMARY INJURY

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

BODY PART 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

INCIDENT LOCATION

☐ Competition area ☐ Concession area
☐ Parking lot ☐ Admission area
☐ Restrooms/locker rooms ☐ Off property
☐ Premises/grounds ☐ Store area
☐ Bleachers/stands
☐ Weight Room
☐ Other

Witness Information:

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

Signature of Coach or Official:_____ **Date:**_____ **Phone: #**_____
(with no relationship to claimant)