

# Special Olympics Michigan

# First Report of Accident / Incident

**Injured Party:**

🞎 Athlete

🞎 Volunteer

🞎 Coach

🞎 Employee

🞎 Spectator

🞎 Unified Partner

🞎 Property Owner

🞎 Other: \_\_\_\_\_\_\_

# Date of Incident: \_\_\_\_\_\_\_\_\_\_\_\_ Area

# Injured Person/Party Information Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Age: \_\_\_\_\_\_

**Type of Injury/ Accident:**

🞎 Bodily Injury

🞎 Property Damage

🞎 Automobile

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# (Last) (First) (MI)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# (Street) (City) (State) (Zip)

# Home Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Gender: 🞎 Male 🞎 Female

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Site / event where accident occurred:

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Power Lifting

🞎 Relay Game

🞎 Snowboarding

🞎 Snowshoe

🞎 Soccer

🞎 Softball

🞎 Speed Skating

🞎 Swimming

🞎 Team Handball

🞎 Track & Field

🞎 Volleyball

🞎 Other: \_\_\_\_\_\_\_\_

Sport

🞎 Alpine Skiing

🞎 Aquatics

🞎 Athletics

🞎 Basketball

🞎 Bocce

🞎 Bowling

🞎 Cross Country Ski

🞎 Cycling

🞎 Figure Skating

🞎 Floor Hockey

🞎 Golf

🞎 Gymnastics

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

🞎 Fatality

🞎 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Home 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MEDICAL ROOM TREATMENT**

History and Description of the Injury/Illness *(Who, What, Where, When, Why, How)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Subjective *(Signs & Symptoms from Victim, Coach or Responsible Party)*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Objective *(Physical findings*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Assessment *(Diagnosis/Impression)*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment Delivered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Further Treatment Advised: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were further treatment instruction forwarded to another site or institution? 🞎 Yes 🞎 No

Medic completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervising Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Review: 🞎 Yes 🞎 No

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

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

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

FAX COMPLETED FORM TO: Special Olympics Michigan, (989) 774-3034

SEND COMPLETED FORM TO: Special Olympics Michigan, Central Michigan University, Mount Pleasant, MI 48859

**If fatality or serious injury: Notify ASIS immediately: 1-800-566-7941 (24 HRS. A DAY/7 DAYS A WEEK), as well as SOMI State Office, 1-800-644-6404**

**SPECIAL OLYMPICS MICHIGAN**

**PROCEDURES FOR FILING AN INCIDENT INSURANCE CLAIM**

NOTE: The accident insurance coverage is "secondary" coverage. If the injured person is covered by other medical coverage, that coverage would be the primary insurance coverage and must first respond to an insurance claim. Please note that this claim form should be completed for both ***accidents*** and ***illnesses****.*

The national insurance provider for secondary accident insurance is American Specialty Insurance Services, Inc. The policy number for the accident policy is DPHPK1750812. **If a fatality or a serious injury should occur, please call 1-800-566-7941- 24 hours a day** and file a claim directed to: American Specialty Insurance Services, Inc., 7609 West Jefferson Boulevard, Suite 150, Fort Wayne, IN 46804-4133 (Fax: 1-260-969-4729)

1. If the party is injured and given medical treatment that would result in a claim (i.e. taken to a hospital/clinic, doctor's office, or emergency room), the FIRST REPORT OF ACCIDENT / INCIDENT FORM should be filled out by the medical person on site in conjunction with the coach. *NOTE: This form can also be used is there is an injury to a spectator or property damage.*

If an athlete is injured, the Health Appraisal form or the Application for Participation ***and*** the Parent Release form ***must*** accompany him/her to the hospital, regardless of insurance coverage.

2. The FIRST REPORT OF ACCIDENT/INCIDENT form should then be sent to the state office to the attention of Ann Harmon. The state office will take care of sending the insurance company the form. After the insurance company receives the claim from SOMI, they will send a Statement of Claim form to the injured party to be filled out if a claim needs to be made.

3. Upon the injured party’s receipt of the claim form, he/she should fill out the form and enclose all ***original*** bills with the claim form when sending it to ASIS. We suggest that the area director keep copies of the completed claim form and all bills for their records in the event a question should arise later.

4. If you receive additional billings after submitting the claim form, send them directly to American Specialty, and they will attend to the payment.

5. If you have any questions, please contact Heidi Alexander at the state office, 1-800-644-6404.

NOTE 1: If someone is injured and given first aid, and not taken to the hospital, clinic, or doctor's office, it is advisable to fill out this form and send it to the state office to keep it on file in case questions come up about the incident later.

NOTE 2: If a fatality or serious injury should occur, please call the American Specialty Insurance Services IMMEDIATELY at 1-800-566-7941, 24 hours a day, seven days a week, as well as the SOMI State Office (1-800-644-6404).

We appreciate your completing the Accident/Incident Report form in a timely manner so that payments can be made promptly.