USGAA Incident Report Form

(PLEASE PRINT)

INJURED PERSON INFORMATION:

Last Name ________________________________ First Name ___________________________MI ____

Employer __________________________________ Spouse's Name _____________________________

(If Minor) Father's Name: ______________________________ Mother's Name_____________________________

Address _______________________________________ Email __________________________________

City __________________________________State _______Zip ________ Phone (_____) __________

Social Security Number ____________ Date of Birth ___________Current Age _______ Male Female

Are you a (choose one): ATHLETE COACH OFFICIAL OTHER ___________________________

TIME, PLACE AND DETAILS OF INCIDENT:

Date of Incident _____________________________ Time of Incident ___________________ AM PM

Body Part Injured: ____

Type of injury (choose one): Laceration Sprain/Strain Fracture Contusion Concussion Other:

____

Severity (choose one): Report only Minor Serious Critical Fatality

Did you receive onsite care? Y N Were you taken by ambulance to a hospital? Y N

What event were you participating in at the time of the incident? ____________________________________

Was there a certified Coach at this event? Y N If so include name _______________________________

What was the location of the event? ____

Describe what happened: ____

____

____

____

Was there a witness to the incident? Y N

WITNESSES:

(If there was a witness please complete this section)

Witness name: ___________________________ Address: _______________________________

_______________________________________ Phone: _________________________________

Witness name: ___________________________ Address: _______________________________

_______________________________________ Phone: _________________________________

FAMILY HEALTH INSURANCE:

(Health Insurance MUST be filed prior to this policy)

Insurance Company: ____

Policy holder's name: ____

Policy Number: ____

Group Number: ____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE AIG, GLOBAL SPORTS SERVICES, OR THEIR REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH AIG, GLOBAL SPORTS SERVICES, OR THEIR REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM. BY MY SIGNATURE BELOW I CERTIFY THAT I HAVE LISTED ANY EXISTING HEALTH INSURANCE COVERAGE ABOVE AND UNDERSTAND THAT OMISSION OF REQUESTED INFORMATION OR FRAUDULENT STATEMENTS CAN BE A CRIME.

Claimant Signature____ Date

____

This section to be completed and signed by NAB GAA Certified Coach or Official:

Club Name of injured: ____

County where incident occurred: ____

I ASSERT THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INCIDENT OCCURRED ON THIS DATE __________

WHILE (athlete, coach or Official name) ______________________________ WAS PARTICIPATING IN A SANCTIONED NAB GAA EVENT.

COACH or OFFICIAL NAME (print) ___________________________________Title ____________

COACH or OFFICIAL SIGNATURE ___________________________________ Date ____________