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 _____