# S.P.O.R.T.S. ACCIDENT REPORT FORM
**Policy Number 14-075530**
**12690 Promise Road**
**Fishers, IN 46038**
**317-845-5582**

## ACCIDENT REPORT FORM TO BE COMPLETED BY THE HEAD COACH.

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN A COPY TO THE S.P.O.R.T.S. OFFICE (FAX # 845-5687) WITHIN 30 DAYS FROM THE DATE OF THE ACCIDENT.

Date Accident Was Reported: _____

Injured Party: _____ Date of Birth: _____

Address: _____

City State Zip:

Home Phone Number: _____ Work/Cell Phone Number: _____

Parents/Guardian information if different from injured party

Parent/Guardian: _____

Address: _____

City State Zip:

Home Phone Number: _____ Work/Cell Phone Number: _____

Team/League Name: _____

Date of Injury: _____ Date of First Treatment: _____ Part of Body Injured: _____

Location of Injury: _____ Accident Time: _____

Where was injured party taken to for medical treatment: _____

Description/Cause of Injury: _____

_____

_____

Witnesses to Injury:

Name: _____

Address: _____

City State Zip:

Home Phone Number: _____ Work/Cell Phone Number: _____

Name of Person Taking Report: _____

At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current member of the Organization? ☐Yes ☐No

Under whose supervision? _____ Was he/she a witness? ☐Yes ☐No

Authorized Signature _____ Title _____ Date _____

**(MUST BE SIGNED BY AN ORGANIZATION OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION ACTIVITY. SIGNATURE IS REQUIRED)**