

# U.S. SKI & SNOWBOARD FIRST REPORT OF ACCIDENT 2018 - 2019

**AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.**

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**COVERAGE UNDERWRITTEN BY:**  
Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza, Omaha, NE 68175

**Club Name:** \_\_\_\_\_

**Injured Person Information**     **A, B, C Team National Member**     **D Team National Member**    **Member #** \_\_\_\_\_  
 **Volunteer Physician**     **General U.S. Ski & Snowboard Member**  
 **National Team Invitees**     **National Training Group**

|                    |       |   |  |                                 |               |
|--------------------|-------|---|--|---------------------------------|---------------|
| Last Name          | First | Middle  | Telephone Number (    )  |                                 |               |
| Address            |       |   | Social Security Number   |                                 |               |
| City               | State | Zip   | <input type="checkbox"/> Male  | <input type="checkbox"/> Female | Date of Birth |
| Email:             |       |   |  |                                 |               |
| Date of Injury:    | Time: | <input type="checkbox"/> am <input type="checkbox"/> pm | Does the injured person have other medical insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   Company: |                                 |               |
| Ski Area/Location: |       |   | Policy #:  |                                 |               |
| Event Name:        |       | Race Code:  |  |                                 |               |

| Incident Location  | Mechanism of Injury   | Sanctioned   | Discipline Ski   |
|--|---|--|--|
| <input type="checkbox"/> Slope/Trail <input type="checkbox"/> Jump<br><input type="checkbox"/> Pool <input type="checkbox"/> Weight Room<br><input type="checkbox"/> Ice Rink <input type="checkbox"/> Camp<br><input type="checkbox"/> Dryland Training<br><br>Activity<br><br><b>Weather Conditions</b><br><input type="checkbox"/> Sunny <input type="checkbox"/> Rainy <input type="checkbox"/> Foggy<br><input type="checkbox"/> Cloudy <input type="checkbox"/> Windy <input type="checkbox"/> Snowing | <input type="checkbox"/> Contact with object<br><input type="checkbox"/> Contact with surface<br><input type="checkbox"/> Illness<br><input type="checkbox"/> No contact<br><input type="checkbox"/> Overexertion<br><input type="checkbox"/> Overuse / Chronic<br><input type="checkbox"/> Pivot shift | <input type="checkbox"/> Competition / Event<br><input type="checkbox"/> Conditioning<br><input type="checkbox"/> On snow training<br><input type="checkbox"/> Other<br><br><b>Surface</b><br><input type="checkbox"/> Artificial<br><input type="checkbox"/> Injected<br><input type="checkbox"/> Natural | <input type="checkbox"/> Adaptive Alpine<br><input type="checkbox"/> Adaptive XC<br><input type="checkbox"/> Aerials<br><input type="checkbox"/> Cross Country<br><input type="checkbox"/> Downhill<br><input type="checkbox"/> Dual Moguls<br><input type="checkbox"/> Giant Slalom<br><input type="checkbox"/> Halfpipe<br><input type="checkbox"/> Moguls<br><input type="checkbox"/> Nordic Jumping<br><input type="checkbox"/> Skicross<br><input type="checkbox"/> Slalom<br><input type="checkbox"/> Slopestyle<br><input type="checkbox"/> Super-G<br><b>Discipline Snowboard</b><br><input type="checkbox"/> Big Air<br><input type="checkbox"/> Giant Slalom<br><input type="checkbox"/> Halfpipe<br><input type="checkbox"/> Slalom<br><input type="checkbox"/> Slopestyle<br><input type="checkbox"/> Snowboardcross |

**Classification of Injury**     Minor Injury or Illness     Non-Injury     Serious Injury or Illness

**Body Part Injured**

|  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Arm <input type="checkbox"/> L <input type="checkbox"/> R   | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Back <input type="checkbox"/> Upper <input type="checkbox"/> Lower | <input type="checkbox"/> Chest   |
| <input type="checkbox"/> Ear <input type="checkbox"/> L <input type="checkbox"/> R   | <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R      | <input type="checkbox"/> Face   | <input type="checkbox"/> Finger  |
| <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R  | <input type="checkbox"/> Groin   | <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R     | <input type="checkbox"/> Head   | <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Internal  | <input type="checkbox"/> Jaw   | <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R     | <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R          | <input type="checkbox"/> Mouth   |
| <input type="checkbox"/> Neck  | <input type="checkbox"/> Nose  | <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Toe  | <input type="checkbox"/> Tooth   |
| <input type="checkbox"/> Thigh   | <input type="checkbox"/> Torso   | <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R    |   |  |

**Primary Injury**

|   |                                       |                                      |                                   |                                      |
|---|---------------------------------------|--------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Abrasion             | <input type="checkbox"/> Cold Injury  | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Fracture | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heat Illness         | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Laceration  | <input type="checkbox"/> Strain   | <input type="checkbox"/> Sprain      |
| <input type="checkbox"/> Suspected Concussion |                                       |                                      |                                   |                                      |

**Disposition**

|  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Air Flight        | <input type="checkbox"/> Continued Sport    | <input type="checkbox"/> EMS Transport                | <input type="checkbox"/> Refer to Physician |
| <input type="checkbox"/> Refer to Hospital | <input type="checkbox"/> Released to Parent | <input type="checkbox"/> Released to Personal Vehicle | <input type="checkbox"/> Refused Care       |

**Description of Accident**

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Signature and printed name of Trainer or Official (with no relationship to claimant) \_\_\_\_\_

Email \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_