



INCIDENT REPORT FORM FOR BODILY INJURY

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. Jefferson Blvd., Suite 150
Fort Wayne, Indiana 46804-4133
Phone: 800-566-7941 | Fax: 260.969.4729



Date of Incident: _____ Time of Incident: _____ AM / PM	Does the Injured Person Have Other Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
If injured person is a League member, identify: League Club Name: <u>Santa Rosa Cycling Club</u>	If yes, please provide: Name of company: _____
Club Address: <u>PO Box 6008 Santa Rosa, CA 95406</u>	Policy #: _____

Injured Person: <input type="checkbox"/> Club Member <input type="checkbox"/> Non-Member <input type="checkbox"/> Participant <input type="checkbox"/> Volunteer <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____	Did This Take Place During: <input type="checkbox"/> Club Ride <input type="checkbox"/> Special Event <input type="checkbox"/> Time Trial <input type="checkbox"/> Race <input type="checkbox"/> Conditioning Event <input type="checkbox"/> Fundraiser
Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If during a Special Event, list name of event: _____
Was the injured person riding: <input type="checkbox"/> Tandem Bike <input type="checkbox"/> Single Bike	Name of League Club putting on the Special Event: <u>Santa Rosa Cycling Club</u>

INJURED PERSON INFORMATION	
Last Name _____ First _____ Mid. _____	Telephone Number () _____ <input type="checkbox"/> Single <input type="checkbox"/> Married
Address _____	Social Security Number (optional): _____
City _____	Employer Name: _____
Age _____ D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Employer Address: _____
GUARDIAN/PARENT (if injured person is a minor)	
Last Name _____ First _____ Mid. _____	Telephone Number () _____
Address _____ City _____ State _____ Zip _____	

SUSPECTED PRE-EXISTING CONDITION: Yes No

INCIDENT LOCATION <input type="checkbox"/> Off Road <input type="checkbox"/> City Street <input type="checkbox"/> Parking Lot <input type="checkbox"/> Highway <input type="checkbox"/> Registration Area <input type="checkbox"/> Rural Road <input type="checkbox"/> Restrooms/Locker Rooms <input type="checkbox"/> Off Property <input type="checkbox"/> Premises/Grounds <input type="checkbox"/> Rest Stop	INCIDENT <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Overexertion <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Eligibility <input type="checkbox"/> Fall (different level) <input type="checkbox"/> Trip/fall <input type="checkbox"/> Fall (same level) <input type="checkbox"/> Slip/fall <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Slip, bodily reaction <input type="checkbox"/> Animal/Insect Bite/Sting <input type="checkbox"/> Chased by dog <input type="checkbox"/> Collision (with parked car) <input type="checkbox"/> Bit by dog <input type="checkbox"/> Collision (with moving car) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (with object/animal) <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Auto/property (also complete reverse side of this form)	WEATHER CONDITIONS <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Foggy <input type="checkbox"/> Snowing <input type="checkbox"/> Cloudy
RIDER ACTIVITY <input type="checkbox"/> Turning right <input type="checkbox"/> Passing <input type="checkbox"/> Turning left <input type="checkbox"/> Intersection <input type="checkbox"/> Being passed <input type="checkbox"/> Straight		ROAD CONDITIONS <input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Icy
CLASSIFICATION <input type="checkbox"/> Minor injury or illness <input type="checkbox"/> Non-injury <input type="checkbox"/> Serious injury or illness		ROAD TYPE <input type="checkbox"/> Paved <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel

PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Nausea <input type="checkbox"/> Amputation <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Stroke <input type="checkbox"/> Abrasion <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Death <input type="checkbox"/> Drowning <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Concussion <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Tooth/Mouth	BODY PARTY INJURED <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> Torso <input type="checkbox"/> Arm (L/R) <input type="checkbox"/> Nose <input type="checkbox"/> Back <input type="checkbox"/> Tooth <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Leg (L/R) <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Internal <input type="checkbox"/> Hip (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Foot (L/R) <input type="checkbox"/> Elbow (L/R) <input type="checkbox"/> Hand (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Finger or Toe	DISPOSITION <input type="checkbox"/> Released to parent <input type="checkbox"/> Police <input type="checkbox"/> Refusal of care <input type="checkbox"/> Ambulance <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Report Only <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Continued riding <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Refer to hospital/clinic
--	---	--

DESCRIBE HOW THE INCIDENT OCCURRED: _____

WITNESS INFORMATION		
NAME	ADDRESS	TELEPHONE NUMBER
1. _____	_____	() _____
2. _____	_____	() _____

Signature of Ride Leader or Official (with no relationship to claimant) _____

Date _____ Phone Number _____

Mail, email or fax a copy to: **SRCC Insurance Coordinator**
PO Box 6008, Santa Rosa, CA 95406
insurance@srcc.com



INCIDENT REPORT FORM FOR AUTO ACCIDENT AND PROPERTY DAMAGE

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. Jefferson Blvd., Suite 150
Fort Wayne, Indiana 46804-4133
Phone: 800-566-7941 | Fax: 260.969.4729

IF THE INJURY OR PROPERTY DAMAGE WAS THE RESULT OF AN AUTO ACCIDENT, PLEASE COMPLETE THIS SECTION:

PERSON DRIVING THE AUTO: _____ Injured Not injured

Address: _____

OWNER OF THE AUTO: _____

Address: _____

MAKE/MODEL/YEAR OF AUTO: _____

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN THE AUTO:

Name: _____ Injured Not injured

Address: _____

Name: _____ Injured Not injured

Address: _____

NOTE: PLEASE USE THE REVERSE SIDE OF THIS FORM TO PROVIDE INJURY INFORMATION. A LIST OF ALL PASSENGERS AND INJURY INFORMATION FOR ALL INJURED PERSONS SHOULD BE PROVIDED; PLEASE USE ADDITIONAL INCIDENT REPORT FORMS OR SEPARATE SHEETS OF PAPER, IF NECESSARY.

PURPOSE OF TRIP: _____

NAME OF POLICE DEPARTMENT WHICH INVESTIGATED THE ACCIDENT: _____

IF THE ACCIDENT INVOLVED A COLLISION WITH ANOTHER AUTOMOBILE, PLEASE COMPLETE THIS SECTION:

PERSON DRIVING OTHER AUTO: _____ Injured Not-injured

Address: _____

OWNER OF OTHER AUTO: _____

Address: _____

MAKE/MODEL/YEAR OF OTHER AUTO: _____

LIST NAMES AND ADDRESSES OF ALL PASSENGERS IN OTHER AUTO:

Name: _____ Injured Not injured

Address: _____

Name: _____ Injured Not injured

Address: _____

(Attach separate sheet of paper, if necessary.)

IF THE ACCIDENT INVOLVED PROPERTY DAMAGE (OTHER THAN AUTOMOBILES), PLEASE COMPLETE THIS SECTION:

If property was damaged, please supply a description of the property and list the owner. (If an auto accident, see above sections.)

Description of property: _____

Description of damage: _____

Owner's name and address: _____

Owner's telephone number: (_____) _____ (day) (_____) _____ (evening)