

LEAGUE OF AMERICAN BICYCLISTS

FIRST REPORT OF BODILY INJURY



AMERICAN SPECIALTY®

AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
 ATTN: CLAIMS DEPARTMENT
 142 N. MAIN STREET, P.O. BOX 459
 ROANOKE, IN 46783
 PHONE: 800-566-7941 FAX: 260-673-1189

Date of Incident: _____ Time of Incident: _____ AM / PM If injured person is an L.A.B. member, identify: L.A.B. Club Name: _____ Club Address: _____	Does the Injured Person Have Other Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: Name of company: _____ 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 _____ Was the injured person wearing a helmet at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the injured person riding: <input type="checkbox"/> Tandem Bike <input type="checkbox"/> Single Bike	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 If during a Special Event, list name of event: _____ Name of L.A.B. Club putting on the Special Event: _____
---	--

INJURED PERSON INFORMATION

Last Name _____ First _____ Mid. _____ Address _____ City _____ Age _____ D.O.B. _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number () _____ <input type="checkbox"/> Single <input type="checkbox"/> Married Social Security Number: _____ Employer Name: _____ Employer Address: _____
---	---

GUARDIAN/PARENT (if injured person is a minor)

Last Name _____ First _____ Mid. _____ Address _____ City _____ State _____ Zip _____	Telephone Number () _____
--	----------------------------

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 (with object/animal) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (participant/pedestrian) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Auto/property (also complete reverse side)	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"/> Electrical Shock <input type="checkbox"/> Nausea <input type="checkbox"/> Amputation <input type="checkbox"/> Foreign Body <input type="checkbox"/> Stroke <input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Death <input type="checkbox"/> Drowning <input type="checkbox"/> Sting/bite <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Contusion <input type="checkbox"/> Illness <input type="checkbox"/> Cold Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Cardiac <input type="checkbox"/> Seizures <input type="checkbox"/> Tooth/Mouth <input type="checkbox"/> Strain/Sprain	BODY PART 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: _____