

North American Tournament Association, LLC
 149 Trailswest Drive
 Chesterfield, MO 63017
 (314) 685-2280 office
 (314) 392-9266 fax

INCIDENT REPORT

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> OTHER: _____						
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ SANCTIONED BY: _____ LOCATION: _____						
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: () _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____						
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> SPECTATOR <input type="checkbox"/> BYSTANDER <input type="checkbox"/> OFFICIAL <input type="checkbox"/> OTHER: _____						
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY						
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____						
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____						
WITNESSES (If known)	<table border="0"> <tr> <td>NAME: _____</td> <td>NAME: _____</td> </tr> <tr> <td>ADDRESS: _____</td> <td>ADDRESS: _____</td> </tr> <tr> <td>PHONE: () _____</td> <td>PHONE: () _____</td> </tr> </table>	NAME: _____	NAME: _____	ADDRESS: _____	ADDRESS: _____	PHONE: () _____	PHONE: () _____
NAME: _____	NAME: _____						
ADDRESS: _____	ADDRESS: _____						
PHONE: () _____	PHONE: () _____						
INSURED	NAME OF INSURED: _____ POLICY#: _____ CLUB NAME: _____ CITY/STATE: _____						
INSURED REPRESENTATIVE	<input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> TRAINER <input type="checkbox"/> PROMOTER <input type="checkbox"/> TEAM/LEAGUE REPRESENTATIVE <input type="checkbox"/> OTHER: _____ NAME: _____ PHONE: () _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____						

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:

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