

Preliminary Accident Details Information Form

Please Note: *The purpose of this form is to help gather the information required for the online Incident Report form. It is NOT the official Incident Report form and cannot be used in place of the online Incident Report form. The fields marked by an asterisk (*) will be required when completing the online Incident Report.*

ELIGIBILITY CHECK LIST

- ☐ Injured party is a member of the USASF
- ☐ Injured party's membership was activated (paid) before the injury occurred
- ☐ Incident/Injury took place at either (A) Gym/Practice Facility at practice or during training OR (B) USASF Sanctioned Competition
- ☐ If athlete is a CHEER participant they were under the direct supervision of an official coach who is a member of USASF, or an employee/paid staff member of the studio/gym.
Name of Supervising Coach _____
- ☐ If athlete is a DANCE participant they were must be under the direct supervision of an official representative of the studio/gym.
Name of Supervising Party (Coach/Director) _____
- ☐ All Star Program/Organization has uploaded their most current proof of insurance to the USASF through their profile.

STEPS TO SUBMIT CLAIM:

Step 1 Read the insurance program summary [CLICK HERE](#)

Step 2 Gather All Required information – use this form to get organized

Step 3 Verify Eligibility via USASF online form [CLICK HERE](#)

You will receive a VERIFICATION CODE from the USASF. You will need this code to submit the form online.

Record Verification Code here _____

Step 4 Follow instructions in the email you receive with the Verification Code to submit your claim online.

Note: Steps 1-3 must be completed by the gym owner or program administrator. Once submitted, the insurance company will work with the injured party (or their parent/guardian if injured party is a minor) and other insurance companies that cover the injured party.

INCIDENT INFORMATION

DATE INJURY OCCURRED (also referred to as LOSS DATE) _____		TIME OF INJURY _____	
AT WHICH LOCATION DID THE INJURY OCCUR?: (please circle one)			
Gym		Sanctioned Event/Competition	
IN WHICH AREA:	<input type="checkbox"/> Practice Floor	<input type="checkbox"/> Competition Floor	<input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Hallway
<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Premises/grounds	<input type="checkbox"/> Bleachers/stands	<input type="checkbox"/> Concession Area <input type="checkbox"/> Admission Area
<input type="checkbox"/> Off property	<input type="checkbox"/> Store/Pro Shop Area	<input type="checkbox"/> Other _____	

DESCRIBE HOW THE INCIDENT OCCURRED *:

INJURED PARTY INFORMATION

☐ Member Athlete Cheer ☐ Member Athlete Dance ☐ Member Coach

FIRST NAME* _____	LAST NAME* _____
USASF MEMBER ID # _____	EXPIRATION DATE _____
DATE OF BIRTH* _____	SOCIAL SECURITY NUMBER: _____
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
ADDRESS* _____	
CITY* _____	STATE _____ ZIP _____
TELEPHONE (_____) _____	EMAIL: _____

INJURED PARTY INSURANCE INFORMATION to include ALL APPLICABLE INSURANCE COVERAGE such as the Club's Participant Accident Policy

INJURED PARTY PRIMARY INSURANCE: COMPANY* _____

POLICY#* _____ GROUP#* _____

PHONE NUMBER: _____

ALL STAR CLUB | GYM | PROGRAM POLICY

COMPANY* _____ POLICY#* _____

PHONE NUMBER* _____

PARENT/GUARDIAN INFORMATION

FIRST NAME* _____ LAST NAME* _____

DATE OF BIRTH* _____ SOCIAL SECURITY NUMBER: _____

ADDRESS* _____

CITY* _____ STATE _____ ZIP _____

TELEPHONE (_____) _____ EMAIL: _____

INJURY INFORMATION

CLASSIFICATION:	<input type="checkbox"/> Non-Injury	<input type="checkbox"/> Minor injury or illness	<input type="checkbox"/> Serious injury or illness
INJURY TYPE:	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Allergy	<input type="checkbox"/> Amputation
	<input type="checkbox"/> Contusion	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Drowning
	<input type="checkbox"/> Fracture	<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Hypertension
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Pain	<input type="checkbox"/> Seizure
	<input type="checkbox"/> Tooth/Mouth	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Sting/Bite
BODY PART:	<input type="checkbox"/> Ankle	<input type="checkbox"/> Arm	<input type="checkbox"/> Back
	<input type="checkbox"/> Face	<input type="checkbox"/> Finger	<input type="checkbox"/> Foot
	<input type="checkbox"/> Internal	<input type="checkbox"/> Knee	<input type="checkbox"/> Leg
	<input type="checkbox"/> Tooth	<input type="checkbox"/> Toe	<input type="checkbox"/> Wrist
SIDE:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Both
	<input type="checkbox"/> Neither		
DISPOSITION:	<input type="checkbox"/> Released to parent	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Refusal of Care
	<input type="checkbox"/> Medical Attention	<input type="checkbox"/> Refer to Doctor	<input type="checkbox"/> Refer to hospital or clinic
	<input type="checkbox"/> Patient requested EMS transport	<input type="checkbox"/> Released to personal vehicle	
INJURY OCCURRED DURING:	<input type="checkbox"/> Practice	<input type="checkbox"/> Competition	<input type="checkbox"/> Travel To or From

WITNESSES INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		
2.		

MEMBER CLUB | GYM | PROGRAM AFFILIATION

GYM NAME* _____ MEMBER ID # _____ EXP. DATE _____

CITY* _____ STATE _____ ZIP _____

CONTACT PERSON (GYM OWNER OR OTHER PERSON REPORTING CLAIM) _____

TELEPHONE (_____) _____ EMAIL: _____