



USA Diving, Inc. 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)	NAME: _____ NAME: _____ ADDRESS: _____ ADDRESS: _____ PHONE: (____) _____ PHONE: (____) _____
INSURED	NAME OF INSURED: <u>USA Diving, Inc.</u> POLICY#: <u>6L KRO-</u> <u>6A SPX-</u> 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:
USA Diving, Inc. • Attention: Insurance Department • 132 E. Washington St., Ste. 850, Indianapolis, IN 46204

THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE BEFORE RETURNING OR PROCESSING MAY BE DELAYED