



Arkansas State Soccer Association
 1100 E. Kiehl Ave. Suite 3 Sherwood, AR. 72120
 Local (501) 833-0550 Toll Free (877) 833-ASSA Fax (501) 835-2176



FIRST REPORT OF SOCCER INJURY

Please complete this form and return to the ASSA office at the above address, **within 30 days of injury**, even if primary insurance should pay the entire amount. A claim and coverage statement will be sent directly to the injured player.

Player's Name: _____ Birthdate: _____ Registration # _____

Address: _____ Phone: () _____

City: _____ State: _____ Zip: _____

Team Name: _____ Team # _____ Age Division: _____

Coach's Name: _____ Phone: () _____

Date of Injury: _____ Where did injury occur? _____

Did injury occur in: Game Situation: ____ Practice Situation: ____ Tournament Situation: ____

If game please provide name of opponent: _____

If tournament please provide name of tournament: _____

Description of injury: _____

Is player covered by primary insurance? Yes _____ No _____

Please attach the referee report (long form): Name of referee: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

I certify that the information provided in this report is accurate.

Signature of injured player or guardian

Signature of coach, referee, or board member

Date: _____

Date: _____

