

PHYSICIAN'S STATEMENT

1. Name of Patient:
2. Diagnosis / Injury:
3. a) Is the condition the direct result of an accident? YES NO
b) If yes, date of the accident (MM/DD/YY):
c) Circumstances:

d) Date of first attendance (MM/DD/Y):
4. Recommended treatments:
5. a) Was the patient hospitalized: YES NO
b) If yes, please provide name of hospital and dates:

These statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (please print):

Address:

Signature of Attending Physician:

Phone Number:

Date (MM/DD/YY):

Fax Number:

ASSOCIATION STATEMENT

- 1. Name of Injured person:
- 2. a) Name of Association:
b) Name of Club / Team:
- 3. The injured person is: Member Volunteer
- 4. Was the person a member or volunteer at the time of the accident? YES NO
- 5. Did the injury occur while the person was participating in an activity approved by the Association?
 YES NO

Please attach a copy of your incident report related to this event (if available).

Signature:

Date (MM/DD/YY):

Title:

Phone Number:

Email:

The furnishing of forms shall not be an admission of liability by the Company.