



# ARIZONA YOUTH SOCCER ASSOCIATION

## INJURY REPORT FORM

Seasonal Yr: \_\_\_\_\_ to \_\_\_\_\_

Status: New Report  Correction  Delete

Injured Person: Player  Coach  Other

Male  Female  Date of Birth MM DD YYYY

Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Area Code

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Member I.D. No.: \_\_\_\_\_

Injury Information: Game  Tournament Game  Practice  Other

Opposing Team Name: \_\_\_\_\_

Location: \_\_\_\_\_ State Affiliation: \_\_\_\_\_

Injury Details: Date Injury Occurred: \_\_\_\_\_ Time \_\_\_\_\_ : \_\_\_\_\_ a.m./p.m. (circle one)

Describe the Incident Below in Detail. Attach Additional Pages If Necessary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Signatures:

Coach: \_\_\_\_\_ Signature: X  
Print Name

Parent/Guardian: \_\_\_\_\_ Signature: X  
Print Name

Parent/Guardian Employer: \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_

Policy No.: \_\_\_\_\_ Area Code

### FOR STATE ASSOCIATION USE ONLY

Date Report Received: \_\_\_\_\_ Date Initial Medical Claim Received: \_\_\_\_\_  
Date Initial Medical Claim Sent: \_\_\_\_\_

Processed By: \_\_\_\_\_ Signature: \_\_\_\_\_  
Print Name

Notes: \_\_\_\_\_  
\_\_\_\_\_

Injury Report Form must be submitted prior to filing a claim. Mail completed form to:

9034 N. 23rd Avenue ☎ Suite 10 ☎ Phoenix, AZ 85021

602-433-9202 ☎ FAX 602-433-9221 ☎ Toll Free 877-723-2972