

**UCA – UDA – ACA**  
**Instructor & Camp Administrator First Report of Injury Form**

This report is to be used only for UCA/ UDA/ ACA Instructors and Camp Administrator injuries. After completing this form, please fax it to **901-251-5849**. If you have any questions, please contact Jennifer Morgan in the Varsity office at **1-800-238-0286, ext. 5845**.

**Date of Injury** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time** \_\_\_\_\_ **am/pm**

**Injured Employee**

**Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
First M.I. Last

**Address** \_\_\_\_\_ **Phone** ( ) \_\_\_\_\_ - \_\_\_\_\_  
Number and Street City State Zip

**Occupation** (job title): \_\_\_\_\_ **Marital Status**  Single  Married **Gender**  Male  Female  
Has employee missed work because of the injury on any date after it occurred? **Yes / No** If yes, give last date worked \_\_\_\_/\_\_\_\_/\_\_\_\_  
Has employee returned to work? **Yes / No** If yes, give date returned to work \_\_\_\_/\_\_\_\_/\_\_\_\_

**Description of the Injury**

Part of body most affected (finger, ankle, etc.) \_\_\_\_\_ Nature of Injury (sprain, fracture, etc.) \_\_\_\_\_  
Describe the injury in detail (what was employee doing: stunting (liberty), tumbling (back handspring), etc.). Please be specific:

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

Injury location (name of university or other location): \_\_\_\_\_ Did injury occur at camp? **Yes / No**  
Name of camp (if applicable) \_\_\_\_\_ Dates of camp \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address of injury location: \_\_\_\_\_  
Street Address City State Zip

**Medical Treatment**

Where was medical treatment provided?  No Medical Treatment  Minor Onsite  Physician/ Clinic  
 ER Treated and Released  Admitted to hospital

Name of Hospital or Clinic: \_\_\_\_\_ Treating Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

Any other important details: \_\_\_\_\_

"I certify that the information given on this form is complete and accurate to the best of my knowledge."

Prepared by: \_\_\_\_\_ Title/ Position: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of injured employee \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If employee is unable or unwilling to sign, please state reason: \_\_\_\_\_

**To expedite the processing of your claims, please provide the following information upon your arrival at the clinic or hospital:**

**Worker's Compensation Carrier Information**

**Liberty Mutual Insurance**

P.O. Box 300  
Brentwood, TN 37024

**Policy #** WC7-151-279957-014

**Billing Fax:** (603) 334-0261

**To verify coverage, please call:** 800-523-6906, ext. 216

**Employer Information**

**Varsity Spirit Corporation**

6745 Lenox Center Court, Suite 300  
Memphis, TN 38115

**FEIN:** 62-1169661

**Contact:** Jennifer Morgan

**Contact Phone:** (901) 251-5845

For Office Use Only

Type of Injury (check one):  First Aid Only  Medical Attention Required - No Lost Time  Medical Attention & Lost Time  
Comments: \_\_\_\_\_