SCMAF PLAYER'S MEDICAL BENEFIT FUND
MANAGER'S REPORT OF ACCIDENT TO PLAYER

THIS IS NOT A CLAIM FORM
FOR QUESTIONS CONCERNING THIS ACCIDENT REPORT FORM
CONTACT YOUR RECREATION DEPARTMENT
THE INJURED PLAYER WILL BE SENT A CLAIM FORM

Send Report to:
SCMAF
P.O. BOX 3605
South El Monte, CA 91733
FAX: (626) 448-5219
SCMAF@scmaf.org

NOTICE: This report must be filled out by the MANAGER of the team immediately after the accident and turned in to the Recreation Department. The LEAGUR DIRECTOR must sign as the SCMAF member and then forward this report to the Players' Medical Benefit Fund Office within 14 days after the accident has occurred.

TYPE OR PRINT LEGIBLY

Name of injured player _____ Sex **M / F** Age _____
First Last

Address _____ Phone ( )_____
Street Apt.# City Zip

E-mail (if applicable) _____ Is the player privately insured? **Y / N**

Team Name _____ Sport _____

Injured player's employer _____ Phone ( )_____

Address_____
Street City Zip

Date of injury _____ Name of opposing team _____

Site _____ City _____ Location on field _____

Type of injury _____

How did injury occur? (Describe in detail) _____

_____

_____

Did injury occur in: Team Practice ❑ Practice game ❑ League game ❑ Other _____
Was Site Director notified of the injury? **Y / N** Was a CITY accident report filled out? **Y / N**
Was first aid rendered? **Y / N** By whom?_____
List witnesses to injury: (three (3) must be listed)

_____
Name Address City Phone

_____
Name Address City Phone

_____
Name Address City Phone

DO NOT SEND DOCTOR BILLS WITH THIS REPORT

I hereby certify the above statements are true to the best of my knowledge.

Signature of Team Manager _____ Date _____

_____
Address City Zip Phone

SIGNATURE OF OFFICIAL WORKING GAME, or
DIRECTOR IN CHARGE OF FACILITY

_____

Signature of SCMAF Member
(Recreation Dept. League Director)

_____

_____
Agency (Keep a copy for your records)