

FORMS FOR DUPLICATION

Important: Be sure to make multiple copies of these forms for continued use.

TRAINING

DVD General Orientation & Registration Form.....	1
Application for Sports Certification.....	2
Application for Sports Re-Certification/Continuing Education	3
SOWI Educational Course Reporting Form for Re-certification	4
Training Site Safety Checklist.....	5

FINANCE

In-Kind Contribution Receipt.....	6
Manual Receipt Form.....	7
Invoice Approval Form.....	8
Agency In-House Petty Cash Request Form.....	9
Petty Cash Ledger	10
Agency Deposit Ticket	11
Agency Deposit Ledger Template	12
Sales Tax Reporting Form.....	13
Money Handling Accountability.....	14
Expense Reimbursement Form.....	15
Certificate of Exemption.....	16
Agency to Agency Funds Transfer Form.....	17
Investment Options Designation Form	18
Investment Options Transfer Form	19

INSURANCE

First Report of Accident/Incident.....	21
Request for Certificate of Insurance	22
Contract Review Checklist.....	23
Insurance Needs Fundraising Event Flow Chart	24

SPORTS

Special Needs Form	25
Athlete Medical Information	26
Motor Activities Training Program.....	27
Sports Competition Event Grant Form.....	28
Filing Protests at Events	29
Disqualifications	30
SOWI Rule Change Form.....	31
International Rule Change Form.....	32
Medical Refund Request	33

FUNDRAISING

Fundraising Project Application	34
Special Event Summary.....	35



**Special
Olympics**
Wisconsin

**SPECIAL OLYMPICS WISCONSIN
DVD ORIENTATION & REGISTRATION FORM
GENERAL ORIENTATION**

PLEASE PRINT OR TYPE CLEARLY:

DATE: _____ Region: _____ CITY: _____ STATE: _____

SITE: _____

SOWI REPRESENTATIVE: _____ SIGNATURE: _____

TITLE: SOWI General Orientation _____ DATE: _____

	NAME	ADDRESS	CITY	STATE	ZIP	AGENCY
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Agency Number: _____



Application for Sports Certification

One form per certification

Instructions: Please print clearly or type information below and return to the State Office.

List **permanent** mailing address and telephone number (not college address):

Name:	Email:
Address:	Home Phone:
City:	Cell Phone:
State: Zip:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Class A Volunteer ID #(optional) :	Occupation:

If you are an SOWI athlete becoming a coach, check this box. ☐

If your address changed since your Class A registration or last certification, please check this box. ☐

I am a Class A registered volunteer with SOWI and have completed the required SOWI General Orientation	YES / NO
I am a Class A registered volunteer with SOWI and have completed the required SOI Protective Behaviors	YES / NO

I am applying for CERTIFICATION in one of the following areas:

	Location of Course:	Date Completed:
Sports Skills:		
Coaching Special Olympic Athletes		
Principles of Coaching		
Coaching Unified Sports		
Athlete Leadership: Coach / Official		
Athlete Leadership: Global Messenger I // II		
Athlete Leadership: Governance		
Games Management		
Official, Sport:		
Other:		

Coaching/Officiating experience at the high school/college levels (circle Coach or Official): Yes ☐ No ☐

Playing experience at high school or college levels: Yes ☐ No ☐

Sport(s) you played: _____

Other Information:

How many SO sports do you coach? _____ How many sports are you certified in? _____

Highest level of education achieved: _____

Do you have any relatives with an intellectual disability? Yes ☐ No ☐ If yes, relationship: _____

☐ I have read the SOWI/SOI/NGB sports rules for the sport listed above, I am familiar with the SOWI Competition Guide and current rule changes, and will comply with the **Certified Coach Code of Conduct**.

Having satisfactorily completed all requirements, I hereby request Special Olympics certification in the area identified above.

Office use only

Signature of Applicant

Date

Signature of Agency Manager

Date

	Initials	Date
BB Check		
Email AM		
BB Entry		

Updated 05/13/2014

Process to Become a Special Olympics Wisconsin Certified Coach

1. Person completing an Application for Sports Certification must be a registered Class A Volunteer, have completed the online General Orientation, and completed an SOWI Certified Training School (CTS).
2. After attending a CTS, application forms must be received by the State Office within one year of the date of attendance – forms received after a year will be void.
****If certification is needed for advancement to State Games, this application must be completed and submitted along with or prior to State Games registration forms.****
3. All lines on the Application for Sports Certification must be filled in:
 - a. Agency number in the top left corner
 - b. Personal contact information in the boxes – please use the full name used on your Class A Volunteer form (i.e. Michelle instead of Shelly)
 - c. Completion status of the *SOWI General Orientation* must be checked YES or NO
Completion status of *SOI Protective Behaviors* must be checked YES or NO
 - d. Check the certification category applying for. If checking *Sport Skills*, please write the specific sport you are applying for (one sport per application)
 - e. Coaching/Officiating experience must be completed
 - f. Education and family background information must be completed
4. The application must be signed by the applying coach and Agency Manager.
5. It is encouraged that applicants and/or Agency Manager make a copy of the form before it is mailed to the State Office.
6. Once the completed form is received and approved, it is entered into the SOWI volunteer database. Coaches will receive a confirmation letter informing them of their new certification and date of expiration. ***All certifications expire on December 31st of the third calendar year from the date of the CTS.*** Before a certification expires, letters are mailed to the coach informing them of the upcoming expiration.
7. If you have any questions, please contact the Director of Training & Competition at 1-800-552-1324, ext. 5679.
8. Please mail, email, or fax the application to the address below:
**Special Olympics Wisconsin
Attn: Director of Training & Competition
2310 Crossroads Drive, Suite 1000
Madison, WI 53718**

Email: alillethun@specialolympicswisconsin.org

Fax: 608-222-3578

Agency Number: _____



Application for Sports Re-Certification

INSTRUCTIONS: Please print clearly or type information below and return to the State office.
List permanent mailing address and telephone number (not college address).

Name _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Class A Volunteer ID# (optional) _____ Occupation _____

☐ If your address above is different from the address shown on your last certification application, please check the box.

I have successfully completed the required SOWI on-line Sports Assessment(s) and I am applying for re-certification in the following sport(s) _____

Additionally, to maintain my sports certification for SOWI, I have completed one of the following educational components:

	Location of Course:	Date Completed:
Sports Skills:		
Coaching Special Olympic Athletes		
Principles of Coaching		
Coaching Unified Sports		
Athlete Leadership: Coach / Official		
Athlete Leadership: Global Messenger I // II		
Athlete Leadership: Governance		
Games Management		
Official, Sport:		
USA/World Games: (date)		
Other:		

☐ I have read the SOWI/SOI/NGB sports rules for the sport listed above, I am familiar with the SOWI Competition Guide and current rule changes, and will comply with the *Certified Coach Code of Conduct*. Having satisfactorily completed all requirements, I hereby request Special Olympics re-certification in the area identified above.

Signature of Applicant

Date

Signature of Agency Manager (Optional)

Date

For Office Use Only

	Initials	Date
RE Check		
SA Check		
Email AM		
BB Entry		



Special Olympics Wisconsin

Process to Maintain Sports Certification

Follow the steps below to maintain your sports certifications. Please note that **ONE** educational course component will re-certify you in all sports if you **also** complete the online sports assessment for **each sport**. If you have other questions about coaching certifications, please visit the FAQs on the website under the volunteer – coaches training tab.

STEP 1: Complete one educational course component – examples include:

- Certified Training School or advanced skills course – must be sport-specific to the certification
- Principles of Coaching or Coaching Special Olympic Athletes (may only be taken one time for re-certification)
- SOWI online course, Coaching Philosophy ***Please include a copy of a completed exercise
- SONA online courses: Principles of Coaching, Coaching Special Olympics Athletes, Coaching Unified Sports ***Please include a copy of the completion certificate
- Online courses through the National Federation of State High School Association (NFHS): www.nfhs.org
- Online courses through American Sport Education Program (ASEP): www.asep.com ***Please include a copy of completion certificate from any online course.
- First Aid/ CPR Certification ***Please attach a copy of the certification card
- SOWI Conference or Health Forum (only if topics are relevant)
- Non-SOWI educational course—i.e. educational or professional in-services, conferences or seminars that pertain to working with people with disabilities, coaching, communication, conflict-resolution, etc.
***SOWI Educational Course Reporting Form must be completed after attendance and submitted with the Re-Certification Application to the State office.

STEP 2: Complete SOWI online Sports Assessment – **for each sport you wish to recertify in**. Sport Assessments are found on our website under the *Volunteer Tab*.

STEP 3: Complete the Application for Sports Re-Certification; Sign and date application and mail, fax, or email directly to the State office:

Mailing Address: Special Olympics Wisconsin
Attn: Director of Training & Competition
2310 Crossroads Drive, Suite 1000
Madison, WI 53718

Email: alillethun@specialolympicswisconsin.org

Fax: 608-222-3578

*****Note:** The Agency Manager signature is optional; Agency Managers will receive an email notification once the application is received and processed.

*****Note:** Application for Sports Re-Certification **must be received at the State office prior to a sports certification expiration date**. If a Re-Certification Application is received after a sports expiration date, it will **not** be accepted.

You have any questions pertaining to the re-certification process or non-SOWI educational course options, please contact the Director of Training & Competition at 1-800-552-1324, ext. 5679 or alillethun@specialolympicswisconsin.org



Agency Number: _____

SOWI Educational Course Reporting Form for Re-Certification

INSTRUCTIONS: Please print clearly or type information below and return to the State office.

To maintain my Sports Certification for SOWI, I have completed the following non-SOWI educational course:

Title: _____

Date: ____/____/____ City: _____

Facilitated by: _____

Please explain the purpose of this course: _____

Please explain how the course applies to your Special Olympic coaching: _____

Please list three to five things you learned from the course that you will apply to your Special Olympics coaching:

1. _____
2. _____
3. _____
4. _____

Having satisfactorily completed all requirements, I hereby request Special Olympics re-certification for coaching.

Applicant Name – print _____

Date _____

Applicant Signature _____

Please mail this form with a Re-Certification Application to:

Special Olympics Wisconsin
Attn: Director of Training & Competition
2310 Crossroads Drive, Suite 1000
Madison, WI 53718

Or E-mail: alillethun@specialolympicswisconsin.org

Or Fax: 608-222-3578

For Office Use Only

	Initials	Date
Dir. of Training & Competition		

Updated 11/1/2012

Special Olympics Wisconsin Training Site Safety Checklist

The new Accreditation standards require that all training facilities and equipment are safe with a first aid kit, athlete emergency contacts and a phone and/or transportation available in case of an emergency.

The checklist below is not intended to cover every possible situation, but acts as a guideline for areas which could constitute injury hazards.

Acceptable?

Yes

No

Playing Surfaces – Indoor

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular floor surfaces (wood separations, splinters, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Surfaces clean and free of dust, gum, wet or greasy areas, loose pieces of paper, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrical floor plate and outlet coverings fixed properly in position? |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrical cords away from participant area and taped securely? |
| <input type="checkbox"/> | <input type="checkbox"/> | All extra equipment removed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Sufficient buffer zone between spectators? |

Playing Surfaces – Outdoor

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Condition of turf (pot-holes, mud, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Puddles drained off? |
| <input type="checkbox"/> | <input type="checkbox"/> | Trash, glass, sharp objects, sharp-edged rocks, etc. removed off the the field? |
| <input type="checkbox"/> | <input type="checkbox"/> | Obvious and hidden grates well-secured? |
| <input type="checkbox"/> | <input type="checkbox"/> | Sufficient buffer zone between spectators? |
| <input type="checkbox"/> | <input type="checkbox"/> | Goal posts, goalie cages, baseball bases, etc. installed properly? |

Walls

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hanging ropes or electrical lines? |
| <input type="checkbox"/> | <input type="checkbox"/> | Moveable equipment flush or appropriately fastened to wall? |
| <input type="checkbox"/> | <input type="checkbox"/> | Protruding handles or cranks? |

Lighting

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | All areas adequately lighted? |
|--------------------------|--------------------------|-------------------------------|

Equipment

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Personal equipment (i.e., clothing, footwear, protective equipment) appropriate to the sport? |
| <input type="checkbox"/> | <input type="checkbox"/> | Activity equipment (i.e., sticks, balls, goals, nets, bats, poles, whistles, cones, padding and mats) can meet the demands of the sport? |
| <input type="checkbox"/> | <input type="checkbox"/> | Athletes have removed jewelry? |

Emergency

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A first aid kit is available on site? |
| <input type="checkbox"/> | <input type="checkbox"/> | A copy of athletes' Application for Participation in Special Olympics Forms with emergency contacts, insurance and medical information is on site? |
| <input type="checkbox"/> | <input type="checkbox"/> | Telephones within easy access? |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle within easy access? |



In-Kind Contribution Receipt

In-kind contributions are services and materials donated in place of cash contributions. In-kind contributions are recorded at fair market value. Fair market value should be established on an objective and clearly measurable basis, i.e., normal charge for a facility, advertised costs for equipment and the posted price for food or beverage.

Date of Contribution: ____ / ____ / ____

Contributor

Name: _____

Business/Organization: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

The information below is required for internal recordkeeping. Per IRS guidelines, Special Olympics Wisconsin is prohibited from establishing monetary values for gifts of real or personal property or stating a value on donor receipts for gifts in-kind. Should you have questions, refer to www.irs.gov publications 526 & 561, and consult your tax advisor. Please retain a copy of this form for your records.

Item/Service	Qty	Unit Price	Total Estimated Value (Provided by Contributor)
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
GRAND TOTAL:			\$ _____

Signature of Contributor: _____ (required)

To be completed by Special Olympics Wisconsin Representative

Purpose of Contribution: _____

SOWI Staff or Agency Manager: _____

Signature

Print Name

Date

In-Kind to be used by (check one):

☐ State ☐ Region # _____

Fund #: 4009- _____

Appeal: _____

Package: _____

Soft Cr: _____

Event Cr: n/a

Ref: _____

☐ Agency # _____

Account #: _____

Reference: _____

Return to: Special Olympics Wisconsin (Specific return address)



Special Olympics Wisconsin Manual Receipt Form

Name of Payee: _____

Agency Number: _____

Amount: _____

Agency Manager Approval: _____

Purpose (be specific): _____

Expense Code: _____

: _____

Date Paid: _____

Why is original receipt missing?: _____

Check Number: _____

Date of Purchase: _____

Name of Payee: _____

Agency Number: _____

Amount: _____

Agency Manager Approval: _____

Purpose (be specific): _____

Expense Code: _____

: _____

Date Paid: _____

Why is original receipt missing?: _____

Check Number: _____

Date of Purchase: _____

****Please note: This form is invalid if Agency Manager has not signed for approval.**



Invoice Approval Form

Name of Payee: _____

Agency Number: _____

Amount: _____

Agency Manager Approval Signature:

Print name

Purpose (be specific – tell who, what, where, when and why):

*Witness Approval Signature:

Print name

***MUST be signed by member of Agency Management Team
who is a Class A volunteer without financial restrictions and
is not a family member of the manager**

Expense Code: _____

Date to be Paid by: _____

Date of Purchase: _____

***Please Note: This form is invalid if the Agency Manager has not signed for approval.**

Agency In-House Petty Cash Request

Agency Number _____

Agency Name _____

Petty Cash Amount Requested \$ _____

Petty Cash for: (Please check one) ☐ Agency Fund or ☐ Special Event

If Special Event: Name of Special Event _____

Date Needed _____

Designated Class A Volunteer _____

This is the person who will be responsible for the petty cash and should have no financial restrictions.
The check will be made out in this persons name.

Address to send check to _____

Approval Signature _____

Agency Manager Signature

Approval Signature _____

Class A Volunteer Signature

Agency number and Name:

[illegible]

AGENCY DEPOSIT TICKET

Use this form to submit deposits to the Program Office.

If deposit includes taxable items such as Admissions, Auction, Concessions, Games & Entertainment or Souvenirs) attach Sales Tax Summary form.

Date		<small>All deposit forms can be found under "Agency Forms & Tools" on our website: www.specialolympicswisconsin.org/agency Contact the Program Office if you need assistance logging in.</small>
Deposit Total		
Total Items for Deposit		
Agency #		
Agency Name		
Submitted by		
Email Address		

Attachments:

- ☐ Sales Tax Summary Form
☐ Bank Deposit Receipt(s)

(For cash deposits made at Johnson Bank. List breakouts - Amount, Account Number & Reference in comments section below)

Comments:

-Use this form to keep an in-house agency record of the deposit.

[illegible]

SALES TAX REPORTING FORM

- Use this form to track taxable items sold at fundraisers and special events.
- Submit completed form with deposit. Taxable items on form must match taxable items in deposit Revenue must be deposited in the month items were sold.



Sales Date:				
Submitted by:				
Sales Event Name:				
Sales Event County:				
Comments:				
Item Description	Sales Tax Category: Admissions, Auction, Concessions, Games & Entertainment or Souvenirs)	Unit Price	x Quantity Sold	= Sales Total
Total				\$

I verify the accuracy and completeness of information listed above:

Signature

Date



2310 Crossroads Drive, Suite 1000
Madison, WI 53718
(608) 222-1324
(800) 552-1324 (toll-free)
(608) 222-3578 (fax)

Money Handling ACCOUNTABILITY

The following procedures will occur at all SOWI fundraising events:

1. At least two people will count money and both individuals will sign off on the counts in order to be held accountable.
 - a. These individuals will be Class A volunteers with no financial restrictions
 - b. These individuals will not be related to each other.
2. This completed form will be forwarded to the State office with the deposit information.

Event: _____

Date: _____

Region: _____

Total Cash: _____

Total Checks: _____

Total Credit Card: _____

Total Collected: _____

Signature

Printed Name

Signature

Printed Name

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication
Values SOWI lives by to create an environment of integrity where winning is more than coming in first.

Created by the Joseph P. Kennedy Jr. Foundation for the benefit of individuals with intellectual disabilities. Authorized and Accredited by Special Olympics, Inc.

**Special Olympics Wisconsin, Inc
Volunteer Expense Reimbursement Form**

Agency Number: _____

Name: _____

Address: _____

Mileage Reimbursement:

Date	Trip/Purpose Explanation	Number of Miles	Allowance (miles x .14)	Account/ Cost Center
Totals				

Other Travel Reimbursement:

Date	Trip/Purpose Explanation	Airfare	Room	Meals	Car Rental/Cab	Account/ Cost Center
Totals						

- Original receipts must be attached

Miscellaneous Expense Reimbursement:

Date	Purpose Explanation	Items to be Reimbursed	Amount	Account/Cost Center
Totals				

- Original receipts must be attached

Approval: _____ **Grand Total:** _____
Agency Manager

Approval: _____ **Date:** _____
Class A Volunteer



WISCONSIN DEPARTMENT OF REVENUE
2135 RIMROCK RD
PO BOX 8949
MADISON, WI 53708-8949

State of Wisconsin • DEPARTMENT OF REVENUE

2135 RIMROCK RD PO BOX 8949 MADISON, WI 53708-8949
PHONE: 608-266-2776 FAX: 608-267-1030 TTY: 608-267-1049
EMAIL: sales10@dox.state.wi.us WEBSITE: www.revenue.wi.gov

April 14, 2011

Letter ID: L1080708032

Batch Index: 1160464896-486

SPECIAL OLYMPICS WISCONSIN INC
2310 CROSSROADS DR STE 1000
MADISON WI 53718-7600

This is your Wisconsin Sales and Use Tax Certificate of Exempt Status (CES). Purchases made by your organization or entity are taxable unless you provide a properly completed Wisconsin Sales and Use Tax Exemption Certificate (Form S-211), listing the CES number shown below, to your supplier(s).

If your organization makes sales, they may be subject to sales tax collection and you may be required to obtain a Seller's Permit. Information regarding registration requirements can be found in our Publication 206, Sales Tax Exemption for Nonprofit Organizations.

Forms and Publications can be obtained through our web site at www.revenue.wi.gov or through our forms ordering line at (608) 266-1961. Many questions can be answered by reviewing the FAQ pages on our web site. You may also contact us by telephone at (608) 266-2776 or by email at sales10@revenue.wi.gov.

**WISCONSIN SALES AND USE TAX
CERTIFICATE OF EXEMPT STATUS (CES)**

(Governmental, Religious, Charitable, Scientific or Educational Organization)

Sales to this organization or entity are exempt from Wisconsin sales and use tax under sec. 77.54(9a) and 77.65(1), Wis. Stats.

This certificate is valid unless cancelled by the Wisconsin Department of Revenue.

SPECIAL OLYMPICS WISCONSIN INC
2310 CROSSROADS DR STE 1000
MADISON WI 53718-7600

CES NUMBER
012517
DATE ISSUED
12/18/1973

IMPORTANT:

Purchases made by your organization are taxable unless you furnish your supplier with the CES number shown above.
Sales by your organization may be subject to tax. If your organization makes taxable sales, it may be required to obtain a seller's permit and remit sales tax to the Department of Revenue.

Questions: Contact the Department of Revenue by telephone at (608) 266-2776, FAX (608) 267-1030, E-mail sales10@revenue.wi.gov, or at our Web site www.revenue.wi.gov

Y:\NP\S - a\1015 (R.0108)

Agency to Agency Funds Transfer

EventDate _____

By signing this form on behalf of my Agency, I authorize the transfer of funds to cover this event.

[illegible]



Investment Options for Agencies Account /Amount Designation Form

Date _____

Agency Number _____

Agency Name _____

Deposit \$ _____ **into the Special Olympics Money Market Savings Account**

Deposit \$ _____ **into the Special Olympics 1year Certificate of Deposit.**

Agency Manager Signature & date 1 _____

Class A volunteer Signature & date 1 _____

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication—Values SOWI lives by to create an environment of integrity where winning is more than coming in first.



Investment Options for Agencies

Transfer Form

Use this form when you wish to transfer money between accounts for your Agency.

This transfer will be made on the 1st business day of the month.

Date _____

Agency Number _____

Agency Name _____

Choose One:

☐ Transfer \$ _____ from my Agency savings account to my Agency checking account.

☐ Transfer \$ _____ from my Agency checking account to my Agency savings account.

Agency Manager Signature 2 _____

Class A volunteer Signature 2 _____

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication—Values SOWI lives by to create an environment of integrity where winning is more than coming in first.



SPECIAL OLYMPICS

FIRST REPORT OF ACCIDENT / INCIDENT



U.S. PROGRAM/AREA: _____ **Date of Incident:** _____ **INJURED PARTY:**

Injured Person/Party Information Date of Birth: ____/____/____ Age: _____

Name: _____

(Last) (First) (MI)

Address: _____

(Street) (City) (State) (Zip)

Home Phone: (____) _____ - _____ **Work Phone:** (____) _____ - _____

Gender: ☐ Male ☐ Female **Social Security Number:** _____ - _____

TYPE OF INJURY/ ACCIDENT:

☐ Bodily Injury
☐ Property Damage
☐ Automobile
☐ Other: _____

INJURED PARTY:

☐ Athlete
☐ Volunteer
☐ Coach
☐ Employee
☐ Spectator
☐ Unified Partner
☐ Property Owner
☐ Other: _____

Description of Accident (if automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____

Site / event where accident occurred: _____

ACCIDENT OCCURRED DURING:	DISPOSITION:	SPORT	BODY PART INJURED:
<input type="checkbox"/> Training/Practice <input type="checkbox"/> Competition <input type="checkbox"/> Traveling to or from SO event <input type="checkbox"/> Other: _____	<input type="checkbox"/> Released to parent <input type="checkbox"/> Refusal of care <input type="checkbox"/> Refer to doctor <input type="checkbox"/> Refer to hospital or clinic <input type="checkbox"/> Medical attention <input type="checkbox"/> EMS transport <input type="checkbox"/> Patient requested EMS transport <input type="checkbox"/> Released to personal vehicle <input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Report only <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Aquatics <input type="checkbox"/> Athletics <input type="checkbox"/> Badminton <input type="checkbox"/> Baseball <input type="checkbox"/> Basketball <input type="checkbox"/> Bocce <input type="checkbox"/> Bowling <input type="checkbox"/> Cheerleading <input type="checkbox"/> Cross Country Ski <input type="checkbox"/> Cycling <input type="checkbox"/> Equestrian <input type="checkbox"/> Figure Skating <input type="checkbox"/> Floor Hockey <input type="checkbox"/> Golf <input type="checkbox"/> Gymnastics <input type="checkbox"/> Kickball <input type="checkbox"/> Power Lifting <input type="checkbox"/> Relay Game <input type="checkbox"/> Roller Skating <input type="checkbox"/> Sailing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Snowshoe <input type="checkbox"/> Soccer <input type="checkbox"/> Softball <input type="checkbox"/> Speed Skating <input type="checkbox"/> Swimming <input type="checkbox"/> Table Tennis <input type="checkbox"/> Team Handball <input type="checkbox"/> Tennis <input type="checkbox"/> Track & Field <input type="checkbox"/> Volleyball <input type="checkbox"/> Other: _____	<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Torso <input type="checkbox"/> Back <input type="checkbox"/> Hand (L / R) <input type="checkbox"/> Finger (L / R) <input type="checkbox"/> Elbow (L / R) <input type="checkbox"/> Shoulder (L / R) <input type="checkbox"/> Leg (L / R) <input type="checkbox"/> Knee (L / R) <input type="checkbox"/> Thigh (L / R) <input type="checkbox"/> Shin (L / R) <input type="checkbox"/> Toe (L / R) <input type="checkbox"/> Other: _____

Contact/Care Provider Information (If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____ **Employer Name:** _____

Name: _____ **Employer Address:** _____

Address: _____ **Work Phone:** (____) _____ - _____

Home Phone: (____) _____ - _____

Does the injured person have medical insurance? ☐ Yes ☐ No

If yes, insurance is provided by: ☐ Injured Person ☐ Care Provider/Responsible Party

Please provide name of Company and Policy Number: _____

Witness Information (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ **Daytime Phone:** (____) _____ - _____

Witness #2 Name: _____ **Daytime Phone:** (____) _____ - _____

Special Olympics Official / Representative (other than claimant)

Name: _____ **Daytime Phone:** (____) _____ - _____

Signature: _____

COMPLETED FORM TO:
AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7 Jefferson Blvd., Suite 150
Fishers, Indiana 46034-4133 | Fax: 260.969.4729

IF INJURY WAS SERIOUS OR A FATALITY:
IMMEDIATELY NOTIFY AMERICAN SPECIALTY
AT 800.566.7941, 24 hours a day/7 days a week

**SPECIAL OLYMPICS
REQUEST FOR CERTIFICATE OF INSURANCE**

(This form is only utilized when a facility/organization requires a certificate of insurance.)

- 1) Date: _____ Person Completing this Form: _____
- 2) U.S. Program/Area: _____
- 3) U.S. Program/Area Address: _____
- 4) U.S. Program/Area Phone No: _____ Fax: _____
E-mail: _____
- 5) Name of Event: _____ Date(s) of Event: _____
- 6) Site or Location of Event: _____
- 7) Is Event a Fundraising Activity? ☐ YES ☐ NO If the event is a Fundraising Activity, please provide answers to the following:
- a. Will the event last more than 7 consecutive days? ☐ YES ☐ NO
- b. Will more than 5,000 spectators/participants be in attendance of the event? ☐ YES ☐ NO
- c. Are participants required to sign a Release of Liability Waiver? ☐ YES ☐ NO

Please attach any pertinent information regarding fundraising activities (brochure, advertisement, specific details)

Note: If the event involves any of the following, please contact Jina Doyle at jdoyle@amerspec.com or (260)673-1127 immediately, as the policy either specifically **EXCLUDES** coverage for these events or requires the U.S. Program to meet certain underwriting requirements. Coverage is not provided for the following activities unless approved in advance by the Insurer.

- Alcohol
- Rock Climbing Walls
- Aircraft (other than a Plane Pull)
- Animals (other than Equestrian practices/competitions)
- Firearms
- Fundraising Events lasting more than 7 consecutive days
- Inflatable Devices
- Mechanical Rides
- Golf Ball Drops
- Fireworks
- Rodeos
- Fundraising Events with more than 5,000 people (including spectators and participants) in attendance

- 8) Is Event Exclusively for Special Olympics Athletes? ☐ YES ☐ NO
- 9) Is Event Sponsored by a Special Olympics Program? ☐ YES ☐ NO
- 10) Is the Event Conducted by a Special Olympics Program? ☐ YES ☐ NO
- 11) Is Alcohol Being Served at the Event? ☐ YES ☐ NO

If so, please provide additional details (such as alcohol is included in ticket price, cash bar, donated): _____

- 12) Certificate Holder (entity requiring certificate): _____
- 13) Does the Certificate Holder require Additional Insured status*? ☐ YES ☐ NO
- a. If so, please outline the requested Additional Insured wording: _____
- b. If so, please outline the Additional Insured's role in the event (such as sponsor, location of event, etc. _____

- 14) Certificate Holder Contact Person: _____
- 15) Certificate Holder Address: _____
- 16) Certificate Holder Phone No.: _____ Fax: _____
E-mail: _____

***ADDITIONAL INSURED STATUS SHOULD BE CHECKED ONLY IF IT IS A REQUIREMENT OF THE CERTIFICATE HOLDER.**

- 17) Are you required to enter into an agreement/contract/permit with another party relative to the above-referenced event that contains assumption of liability, indemnification, or hold harmless language? ☐ YES ☐ NO
- If so, please send a copy of the contract with the Certificate Request Form.

Original Certificate should be sent to: ☐ Certificate Holder ☐ U.S. Program

SEND TO:
ATTN: RENE WATERSON E-MAIL: rwatson@amerspec.com
AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
P.O. BOX 309
ROANOKE, IN 46783-0309 TELEPHONE: (800) 245-2744 FAX: (260) 672-8835

Special Olympics Wisconsin Contract Review Checklist

Purpose of Checklist

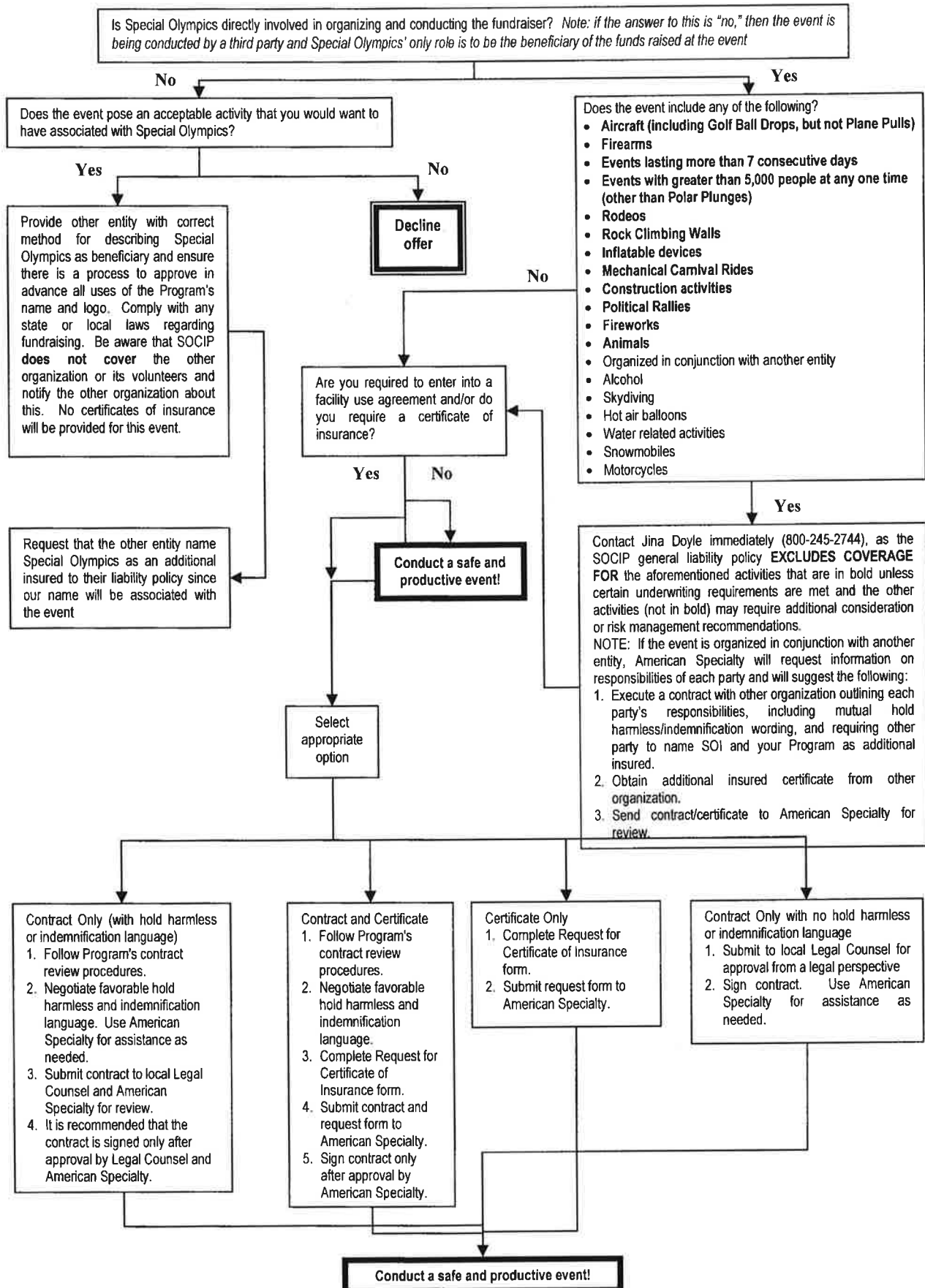
The following checklist is provided as a tool to help Special Olympics U.S. Programs when determining whether to sign a contract/agreement with a venue or facility. This checklist focuses on risk management issues and applies primarily to facility or venue use agreements/contracts. Although some of the same principles may apply, this checklist is not intended to be used for contracts such as hotel agreements, sponsorship agreements, long-term building leases, etc. A U.S. Program should always follow its own protocol relative to the contract review process and should work with legal counsel and insurance representatives (American Specialty or local broker) as appropriate.

Using the Checklist

If the answer to any of the questions below is "no," separate action is recommended prior to signing. Also, please utilize the Event Flowchart to help identify any additional steps that may need to be taken relative to insurance.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a complete, legible copy of the contract?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are all parties listed by their formal legal names?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the effective dates and times of the agreement accurately stated?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the individuals to sign the agreement authorized representatives of each party?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the indemnification and hold harmless provision "acceptable"?</p> <p>Acceptable:</p> <ul style="list-style-type: none"> • Other party indemnifies and holds Program harmless for losses, and Program doesn't indemnify or hold other party harmless; or • Each party is responsible for its own negligence - mutual indemnification and hold harmless; or • Program indemnifies and holds other party harmless but not for losses arising from other party's negligence (or other party's sole or gross negligence). This is acceptable although above options are preferable. <p>Not Acceptable</p> <ul style="list-style-type: none"> • Program indemnifies other party and holds them harmless for any and all losses (including those arising from other party's own negligence), and other party doesn't indemnify or hold Program harmless.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the Program carry the insurance coverage required in the contract?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the additional insured requirement consistent with the indemnification and hold harmless provision?</p> <p>For example:</p> <ul style="list-style-type: none"> • If there is mutual hold harmless and indemnification, the parties should name each other as additional insured. • If the Program must hold harmless and indemnify the other party for losses arising out of the Program's negligence only, then the Program should be required to name the other entity as an additional insured only with respect to losses arising out of the Program's negligence.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the cancellation requirements acceptable (for example, they do not place an undue financial burden on the Program if the Program needs to cancel)?

Insurance Needs Fundraising Event Flowchart



SPECIAL NEEDS ATHLETE FORM

Completed Special Needs Forms can be copied, but must be submitted at the registration deadline for ALL levels of competition.

Coaches who have athletes with special needs (i.e. communication limitation, hearing or visual impairment, special equipment adaptations or behavioral needs) can relay important information to the event volunteer as to how to best work with the athlete. In some cases, a coach may be allowed to be in the competition area for consultation with the volunteer(s) working with the athlete. It is important in this situation for the coach to introduce the athlete to the volunteer(s) and advise the volunteer(s) on how to work with the athlete. The coach will not be allowed to remain in competition area. **Special needs forms are intended to be an aid for the volunteer in working with the athlete and are not to be used for performance-related instructions or coaching tips.**

If you have a "Special Needs" athlete please complete the following form (one per athlete). If necessary, this information will be included on the event card. If you do not complete this form, it may be more difficult to accommodate the "Special Needs" for your athlete.

Athlete Name:
Agency Number and Name:
Coach Name:

☐ **REQUEST 1:1 Volunteer needed in competition area**

- Must obtain prior approval from Event Director (not all requests can be approved).
- Check reason(s) and provide a brief explanation below

☐ **REQUEST 1:1 State Games Housing Chaperone** (non-competition related) – provide a brief explanation below
1:1 Class A Chaperone Name: _____ (must match your Coach/Chaperone Roster)

☐ **General Volunteer assistance at the venue** – check reason(s) or provide a brief explanation below

General Special Needs: (check all that apply)	
<input type="checkbox"/> Guide to/from event/start	<input type="checkbox"/> Non Verbal
<input type="checkbox"/> Behavior issues	<input type="checkbox"/> Hearing Impaired
<input type="checkbox"/> Wanders	<input type="checkbox"/> Visually Impaired
<input type="checkbox"/> Unsteady on feet	<input type="checkbox"/> Seizures
<input type="checkbox"/> Special Equipment – explain below:	<input type="checkbox"/> Medical condition that may require the administration or consumption of medication, food or liquids <u>during competition</u> . – provide a <u>brief</u> explanation below.
<input type="checkbox"/> Other – explain below:	

Explanation: (Please be as brief as possible):



ATHLETE MEDICAL INFORMATION

Agency: _____ Coach: _____ Sex: ☐ M ☐ F
Athlete Name: _____
Address: _____

Date of Birth: _____ S.S. #: _____
Doctor: _____ Phone: _____

Specialty: _____
Doctor: _____ Phone: _____

Specialty: _____
EMERGENCY CONTACTS

1) Name: _____ Phone: _____
Address: _____

2) Name: _____ Phone: _____
Address: _____

Able to Make Own Medical Decisions ☐ Y / ☐ N

MEDICAL INSURANCE

Company Name: _____
Policy Number: _____
Company Name: _____
Policy Number: _____

GENERAL HEALTH INFORMATION

Pain Tolerance: ☐ Low ☐ Normal ☐ High
Last Tetanus Shot _____
If applicable: _____
Last Influenza Shot _____ Last Pneumococcal Shot _____
MEDICAL DATA AS OF: Month _____ Year _____

MEDICAL HISTORY (Check all that exist)

☐ No known medical conditions
☐ Asthma
☐ Diabetes
☐ Seizure Disorder
☐ Hypertension

☐ Coronary Artery Disease
☐ Bleeding/Clotting Disorder
☐ Stroke
☐ Hearing Impaired ☐
Other/Details _____

☐ Pacemaker
☐ Sickle Cell Anemia
☐ Dementia
Vision Impaired _____

ALLERGIES (Please describe reaction)

☐ No known allergies ☐ Environmental ☐ Aspirin
☐ Insect Stings ☐ Latex ☐ Penicillin
☐ Ibuprofen ☐ Tylenol
Other Allergies _____

Reaction Description(s) _____

MEDICATIONS

Name	Dose	Frequency	Indication

Athlete Medical Information Instructions

The following are additional questions/clarification to assist you in providing the most accurate and relevant medical information to Special Olympics-WI coaches and medical staff, in addition to emergency medical personnel, if needed. Please feel to provide sensitive information via other methods.

Emergency Contact

Is the athlete able to make own medical decisions?

If no, please indicate on form and list who is able to make such decisions, i.e. guardian/Power of Attorney for Healthcare, as Emergency Contact #1.

General Health Information: Please see below and the back of this sheet for a list of questions.

Medical History: Please check/list all current medical problems, major surgery/illness, and medical conditions that may alter evaluation or treatment. In addition, please see below and back side of this sheet for questions about certain conditions.

Allergies: Please check/list any allergies (medication, food, latex, other). Include type of reaction (Anaphylactic (trouble breathing, throat swelling), rash, GI problems, other)

Medications: Please list all medications, vitamins and supplements taken. In addition, list any recent medication changes and medication side effects that need to be watched for (sun sensitivity, dehydration, etc) in the General Health Information Section. Also, please include if and what over-the-counter medications the athlete may have for minor pain, etc.

General Medical Information Questions: Please indicate answers in the General Health Information or Medical History Sections (only need to provide information if answer is different than "normal")

General Information

- Is the athlete unable to answer the following?
 - Date, Place, Date of Birth
- Does the athlete have any significant weakness, paralysis, decreased sensation, deformity, spasticity, or rigidity?
- Does the athlete have any hearing, eye or vision problems, especially unequal pupils?
 - Any communicative disabilities?
- Does the athlete have any chronic skin conditions?
- Any "missed" immunizations?
- Any significant family history (heart disease, diabetes, cancer)?
- Any medical dietary restrictions? Please indicate reason for restriction.

Female Specific

- Does the athlete have heavy menstrual bleeding or cramping?
- Does she know her menstrual cycle?
- Any possibility of pregnancy?

Behavioral/Disability Conditions

- Does the athlete need assistance with personal cares, meals, daily activities, etc.?
- Any behavioral problems or psychiatric diagnoses?
 - Triggers? Interventions? Medications?

Heart/Lung Conditions

- Does the athlete have a heart or lung condition that places them at higher risk of illness or injury? [determined by a physician]
- Does the athlete have high blood pressure, irregular heart rhythm, heart murmur, or bleeding problems?
 - Do they take medication?

Gastrointestinal Conditions

- Does the athlete have chronic over/under eating, heartburn, constipation, diarrhea, or abdominal pain?
 - Medication?
 - Treatment (foods to avoid, etc)

Headaches/Migraines

- Does the athlete often get headaches/migraines?
- How severe are they?
 - Complications: vomiting, visual changes, etc?
- How long do they last?
- What treatment is most effective?

Urinary Conditions

- Does the athlete have frequent urinary tract/bladder infections?
 - Signs/Symptoms?
 - Frequency of infections?
 - Usual Medication (antibiotic prescribed by a physician)

Specific Medical Condition Questions

Seizures

- Are they true seizures, pseudo-seizures, fake/behavioral seizures?
- Please describe in detail a typical seizure, including frequency, duration, body movements, staring, post-seizure recovery behavior/duration, reasons for going to the emergency department.
- Recent medication changes?

Diabetes

- Do they have a glucometer? Are they able to check their own blood sugar? How often do they check their blood sugar levels?
- Is there any medication that needs to be adjusted for missed meals or increased activity? If so, which medications and how?
- Do they often have episodes of low blood sugar?

Asthma

- Do they have asthma?
 - Triggers?
 - How severe is their asthma?
 - How often do they have an attack?
 - How severe is their attack?
 - Recent ED visits/hospitalizations?
- History of ICU visits/intubations?

MOTOR ACTIVITIES TRAINING PROGRAM (MATP) SANCTION FORM

This form must be completely filled out and submitted to the Program office at least eight weeks prior to the scheduled training day activity. Challenge award ribbons will be mailed out to MATP programs two weeks prior to the event.

PLEASE PRINT OR TYPE

MATP Coordinator: _____

Phone: Daytime: _____ Evening: _____

E-mail Address: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Estimated number of MATP Special Olympics athletes participating: _____

Estimated coach-to-athlete ratio: _____

Training Dates: _____

Training Site: _____
(Location) (City)

Training Day Activity Site (if different): _____
(Location) (City)

Mail eight weeks prior to training day activity to:

**Special Olympics Wisconsin
2310 Crossroads Dr. Ste. 1000
Madison, WI 53718
Attn: Director of Training and Competition**