



USA VOLLEYBALL INCIDENT REPORT FORM INJURY OR PROPERTY DAMAGE

Submit this form to:

Brian Hofman
7713 Ada Road
Harrod, Ohio 45850

SUBMIT THIS FORM TO YOUR REGIONAL VOLLEYBALL OFFICE (ADDRESS ABOVE)

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name _____ First _____ Middle _____	Phone #: (____) _____
Age _____ D.O.B. _____ <input type="checkbox"/> Male / <input type="checkbox"/> Female	Does the injured person have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name of company and policy #:
Date of Incident _____ Time of Incident _____ <input type="checkbox"/> AM / <input type="checkbox"/> PM	INJURED PERSON: <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach
Event Name: _____	<input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____
Team Name: _____	GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)
USAV Region: _____	Last Name _____ First _____
USAV Membership #: _____	Phone #: (____) _____

INCIDENT INFORMATION

BODY PART INJURED <input type="checkbox"/> Ankle (L/R) <input type="checkbox"/> Shoulder (L/R) <input type="checkbox"/> Back <input type="checkbox"/> Knee (L/R) <input type="checkbox"/> Wrist (L/R) <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Finger <input type="checkbox"/> Internal <input type="checkbox"/> Head <input type="checkbox"/> Eye (L/R) <input type="checkbox"/> No Injury <input type="checkbox"/> Tooth <input type="checkbox"/> Ear (L/R) <input type="checkbox"/> Other	If Ankle Injury, was ankle <input type="checkbox"/> Taped <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Shoes: <input type="checkbox"/> Yes <input type="checkbox"/> No If Knee Injury, was knee: <input type="checkbox"/> Braced <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Knee Pads: <input type="checkbox"/> Yes <input type="checkbox"/> No	INCIDENT <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Overexertion <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Property Damage <input type="checkbox"/> Animal/insect bite/sting	
SURFACE CONDITIONS <input type="checkbox"/> Slippery/Wet <input type="checkbox"/> Asphalt <input type="checkbox"/> Grass <input type="checkbox"/> Concrete <input type="checkbox"/> Wood <input type="checkbox"/> Sand If sport court, what is under-lying surface? <input type="checkbox"/> Wood <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt	INCIDENT LOCATION <input type="checkbox"/> Before Competition/Event <input type="checkbox"/> During Competition/Event <input type="checkbox"/> After Competition/Event <input type="checkbox"/> Competition area <input type="checkbox"/> Concession area <input type="checkbox"/> Parking lot <input type="checkbox"/> Admission area <input type="checkbox"/> Restrooms/locker rooms <input type="checkbox"/> Off property <input type="checkbox"/> Bleachers/stands	PRIMARY INJURY <input type="checkbox"/> Allergy <input type="checkbox"/> Dislocation <input type="checkbox"/> Amputation <input type="checkbox"/> Nausea <input type="checkbox"/> Foreign Body <input type="checkbox"/> Burn <input type="checkbox"/> Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiac <input type="checkbox"/> Cold Injury <input type="checkbox"/> Contusion <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Seizures <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Concussion <input type="checkbox"/> Abrasion <input type="checkbox"/> Sting/bite <input type="checkbox"/> Illness <input type="checkbox"/> Death	DISPOSITION No care given: <input type="checkbox"/> Patient refused <input type="checkbox"/> Not needed Released: <input type="checkbox"/> To parent <input type="checkbox"/> To personal vehicle Referral <input type="checkbox"/> To doctor <input type="checkbox"/> To hospital/clinic EMS transport: <input type="checkbox"/> Trainer recommended <input type="checkbox"/> Patient/parent requested

Describe how the injury or property damage occurred: (attach a separate sheet if necessary)

WITNESS INFORMATION

Name	Address	Telephone Number
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		()

Tournament Director, Club Director, Coach and/or USA Volleyball Official completing this form:

Name: _____ Signature: _____
Title: _____ Date: _____ Phone #: (____) _____
Region Signature: _____