



USA VOLLEYBALL INCIDENT REPORT FORM INJURY OR PROPERTY DAMAGE

Submit this form to:
Nancy Funk
Pioneer Region
7906 Ferndale Rd.
Louisville, KY 40291

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

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

Last Name First Middle	Telephone Number ()	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address	Social Security Number _____	
City _____ State _____ Zip _____ Age _____ D.O.B _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Employer and Address _____	
Date of Incident _____ Time of Incident _____ AM/PM Team Name: _____ Region: _____ USAV Membership #: _____	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 #: _____ INJURED PERSON: <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____	

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name First Middle	Telephone Number ()
Address City State	Zip

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		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	
COURT SURFACE <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt <input type="checkbox"/> Grass <input type="checkbox"/> Sand <input type="checkbox"/> Wood <input type="checkbox"/> Sport Court <i>If sport court, what is under-lying surface?</i> <input type="checkbox"/> Wood <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt	INCIDENT LOCATION <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 <input type="checkbox"/> Not needed <i>EMS transport:</i> <input type="checkbox"/> Trainer recommended <input type="checkbox"/> Patient/parent quested

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

WITNESS INFORMATION		
Name	Address	Telephone Number
1.		()
2.		()

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

Name: _____ Signature: _____

Title: _____ Date: _____ Phone #: () _____

Event Name: _____

Event Location: _____

Sanctioning Region: _____ Region Signature: _____

Region Use Only: For processing, please submit this form to: American Specialty, Lowell Gratigny, Post Office Box 459, Roanoke, IN 46783; Phone: 260-673-1128 or 800-245-2744; Fax: 260-672-8835 lgratigny@amerspec.com