



# USA VOLLEYBALL INCIDENT REPORT FORM INJURY OR PROPERTY DAMAGE

**Submit this form to:**  
 Rocky Mountain Region:  
 office@rmrvolleyball.org &  
 executivedirector@rmrvolleyball.org

**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"/> / <input type="checkbox"/> AM/PM	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: _____
Event Name: _____			<b>GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)</b>
Team Name: _____			
USAV Region: _____			
USAV Membership #: _____			
Last Name _____		First _____	
Phone #: (____) _____			

### INCIDENT INFORMATION

<b>BODY PART INJURED</b> <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	<b>If Ankle Injury, was ankle</b> <input type="checkbox"/> Taped <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Shoes: <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>If Knee Injury, was knee:</b> <input type="checkbox"/> Braced <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported Knee Pads: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>INCIDENT</b> <input type="checkbox"/> Collision (participant/spectator) <input type="checkbox"/> Collision (with object) <input type="checkbox"/> Collision (participant/participant) <input type="checkbox"/> Collision (spectator/spectator) <input type="checkbox"/> Struck by falling/flying object <input type="checkbox"/> Caught in, on, between <input type="checkbox"/> Animal/insect bite/sting  <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Overexertion <input type="checkbox"/> Assault/Sexual <input type="checkbox"/> Assault/Non-Sexual <input type="checkbox"/> Property Damage	
<b>SURFACE CONDITIONS</b> <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  <i>If sport court, what is under-lying surface?</i> <input type="checkbox"/> Wood <input type="checkbox"/> Concrete <input type="checkbox"/> Asphalt	<b>INCIDENT LOCATION</b> <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	<b>PRIMARY INJURY</b> <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	<b>DISPOSITION</b> <i>No care given:</i> <input type="checkbox"/> Patient refused <input type="checkbox"/> Not needed <i>Released:</i> <input type="checkbox"/> To parent <input type="checkbox"/> To personal vehicle  <i>Referral</i> <input type="checkbox"/> To doctor <input type="checkbox"/> To hospital/clinic  <i>EMS transport:</i> <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
		(    )
		(    )

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Title: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: (    ) \_\_\_\_\_  
 Region Signature: \_\_\_\_\_