



# USA Volleyball Incident Report Form Injury or Property Damage

Send this form to:  
 Lowell Gratigny  
 American Specialty  
 142 N. Main Street, Roanoke, IN 46783  
 Phone: 260-673-1128 or 800-245-2744  
 Fax: 260-673-1291  
 lgratigny@amerspec.com

### INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number</b> ( )	<input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>Married</b>
<b>Address</b>			<b>Social Security Number</b> _____	
City _____ State _____ Zip _____			<b>Employer and Address</b> _____	
Age _____ D.O.B _____ <input type="checkbox"/> Male <input type="checkbox"/> Female				
<b>Date of Incident</b> _____ <b>Time of Incident</b> _____ <b>AM/PM</b>			<b>Does the injured person have other medical insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Team Name:</b> _____			If yes, please provide name of company and policy #: _____	
<b>Region:</b> _____			<b>INJURED PERSON:</b> <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____	
USAV Membership #: _____				

### GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Telephone Number</b> ( )
<b>Address City State</b>			<b>Zip</b>

### 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	<i>If Ankle Injury, was ankle</i> <input type="checkbox"/> Taped <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported <i>Shoes:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>If Knee Injury, was knee:</i> <input type="checkbox"/> Braced <input type="checkbox"/> Supported <input type="checkbox"/> Unsupported <i>Knee Pads:</i> <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"/> 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"/> <b>Property Damage</b> <input type="checkbox"/> Animal/insect bite/sting	
<b>COURT SURFACE</b> <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"/> 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
1.		( )
2.		( )

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

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