



# USA VOLLEYBALL INCIDENT REPORT FORM INJURY OR PROPERTY DAMAGE

Submit this form to:  
**CHRVA/Lisa DiGiacinto**  
 114 Broadview Blvd N  
 Glen Burnie, MD 21061

**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 _____  |       | Employer and Address _____   |                              |  |
| Age _____ D.O.B _____ <input type="checkbox"/> Male <input type="checkbox"/> Female |       |  |                              |  |
| Date of Incident _____ Time of Incident _____ AM/PM                                 |       | Does the injured person have other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please provide name of company and policy #: |                              |  |
| Team Name: _____  |       | INJURED PERSON: <input type="checkbox"/> Participant <input type="checkbox"/> Official <input type="checkbox"/> Coach  |                              |  |
| Region: _____   |       | <input type="checkbox"/> Spectator <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____  |                              |  |
| USAV Membership #: _____  |       |  |                              |  |

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

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

### INCIDENT INFORMATION

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