



USA VOLLEYBALL INCIDENT REPORT FORM INJURY OR PROPERTY DAMAGE

Submit this form to:

OKRVA
18605 Alberto Place
Edmond, OK 73012
405-285-0607 (fax)
registrar@okrva.com

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

INJURED PERSON INFORMATION / PROPERTY DAMAGE OWNER

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

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

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

INCIDENT INFORMATION

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