WATER RECREATION PROGRAM

Illness and Injury Facility Report Form

Reporting requirement: The owner or operator must report any death, near drowning or serious injury to the health department within 48 hours (RCW 70.90 and WAC 246-260). A serious injury means someone has called for emergency aid (such as 911) and/or person needs immediate medical treatment at a clinic or emergency room and/or is admitted to a hospital.

Please return this form: Spokane Regional Health District
Environmental Public Health Division
1101 W. College Avenue
Spokane, WA 99201

Need help? If help is needed in completing this form call Spokane Regional Health District at (509) 324-1560 ext. 4 or the state Department of Health at (360) 586-8131.

Facility Info		
	Name:	**Address**:
	Phone Number:	**County:**

Ill/Injured person information					
	Name:				
	Phone Number:	**Cell #**:			
	Address:				
	☐ **Male** ☐ **Female**	**DOB:**	**Age:**	**Height:**	**Weight:**
	Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Unknown ☐ Other:				

Incident Information			
	Date of Illness/Injury:	**Day of week:**	**Time of day:**
	Describe how the injury occurred:		
	Type of injury/illness: ☐ Bruise ☐ Laceration ☐ Sprain ☐ Fracture ☐ Concussion ☐ Internal organ injury ☐ Spinal injury ☐ Near drowning ☐ Drowning ☐ Vomiting ☐ Diarrhea ☐ other ☐ Non-specific ☐ unknown ☐ other:		
	Area(s) of body injured: ☐ Arm ☐ Back ☐ Leg ☐ Face ☐ Foot/ankle ☐ Hand/wrist ☐ Head ☐ Trunk ☐ Immersion(lungs) ☐ Unknown ☐ Other:		
	Location where injury occurred: ☐ Indoor ☐ Outdoor ☐ Pool water ☐ Deck/walkway ☐ Locker room ☐ Unknown ☐ Other:		
	Injured transported to: ☐ Personal physician/clinic ☐ Emergency room ☐ Pronounced dead at scene ☐ Treated and released ☐ Returned home		
	Individual or guardian transported by: ☐ Emergency response ☐ Family member or friend ☐ Other:		
	Result of injury: ☐ Death ☐ Hospitalized ☐ Treated and released ☐ Unknown ☐ Other:		

Reporter Information		
	Report prepared by:	**Date report prepared:**
	Title/agency:	
	Address:	
	Phone:	

To Be Completed by SRHD		
	Facility ID #:	**Case #:**
	Inspector assigned:	**Date report sent to DOH**: