Land Travel Illness or Death Investigation Form
U.S. Centers for Disease Control and Prevention

Form Approved
OMB Control No.0920-0821
Exp XX/XX/XXXX

Section 1. Quarantine station notification

QARS Unique ID #:	CDC User ID:	Port of Entry:	State:
Person notifying CDC:	Phone:	Email:	
Agency notifying CDC:	Date of initial notification to CDC: _____/_____/______ (mm dd yyyy)	Time of initial notification to CDC (24 hrs): _____ : _____ (hh : mm)	

Type of notification: ☐ Illness ☐ Death

Type of traveler: ☐ Crew ☐ Passenger ☐ N/A

Where was the traveler when the QS was notified?:
- ☐ In U.S. jurisdiction
- ☐ In foreign jurisdiction
- ☐ Unknown

When was the Quarantine Station notified?:
- ☐ Before any travel was initiated
- ☐ During travel
  - ☐ Prior to boarding conveyance
  - ☐ While traveler was on a conveyance
  - ☐ After disembarking conveyance
- ☐ After travel completed (reached final destination for that leg of trip)
- ☐ Unknown

NOTE: If ill/deceased person also traveled via ☐ Air and/or ☐ Maritime conveyances, please fill out the appropriate form and attach

Section 2: Pertinent medical history of ill or deceased person

Relevant history: present illness, other medical problems, vaccinations, etc.:

Traveler has taken:
- ☐ Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with date(s) started: ____
- ☐ Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the **past 12 hrs**; list with time of last dose: ___________________________
- ☐ Other medications (related to current symptoms/illness); list with date(s) started: ____

Relevant Exposures:

Countries visited in the past 3 weeks:	State/city/village	Arrival date	Exposure to ill persons?	Exposure to animals?	Other exposures (chemical, drug ingestion, etc)?
			☐ No ☐Yes, _____________	☐ No ☐Yes, _____________	☐ No ☐Yes, _____________
			☐ No ☐Yes, _____________	☐ No ☐Yes, _____________	☐ No ☐Yes, _____________
			☐ No ☐Yes, _____________	☐ No ☐Yes, _____________	☐ No ☐Yes, _____________

Signs, Symptoms, and Conditions (check all that apply) :

☐ FEVER (≥100˚F or ≥38°C) **OR** feeling feverish/having chills in past 72 hrs
Onset date: _____/_____/______
Current temperature: ______⁰ F/C

☐ Rash
Onset date: _____/_____/______
Appearance:
☐ Maculopapular ☐ Vesicular/Pustular
☐ Purpuric/Petechial ☐ Scabbed ☐ Other

☐ Conjunctivitis/eye redness
Onset date: _____/_____/______

☐ Coryza/runny nose
Onset date: _____/_____/______

☐ Persistent cough
Onset date: _____/_____/______
☐ With blood ☐ Without blood

☐ Sore throat
Onset date: _____/_____/______

☐ Difficulty breathing/shortness of breath
Onset date: _____/_____/______

☐ Swollen glands
Onset date: _____/_____/______
Location: ☐ Head/neck ☐ Armpit ☐ Groin

☐ Vomiting
Onset date: _____/_____/_______
Number of times in past 24 hrs? ______

☐ Diarrhea
Onset date: _____/_____/_______
Number of times in past 24 hrs?: ______

☐ Jaundice
Onset date: _____/_____/______

☐ Headache
Onset date: _____/_____/______

☐ Neck stiffness
Onset date: _____/_____/______

☐ Decreased consciousness
Onset date: _____/_____/______

☐ Recent onset of focal weakness and/or Paralysis
Onset date: _____/_____/______

☐ Unusual bleeding
Onset date: _____/_____/______

☐ Obviously unwell

☐ Injury

☐ Chronic condition

☐ Asymptomatic

☐ Other: ______________________________
____

Deceased Persons:	Date of Death: ______/______/__________ (mm dd yyyy)	Time of death (24 hours): _____:_____ (hh : mm)

Presumptive Diagnosis or Cause of Death:

If traveling by conveyance, does anyone else have similar illness?: ☐ No ☐ Yes ☐ Unknown (If yes, please fill in a new form for each person in the cluster.)

Response or Report:
☐ Requires DGMQ Response & Follow-up **(Proceed to next section)**
☐ Information Report Only / No Follow-up Needed **(STOP HERE)**

Section 3. General information about the ill or deceased person

Last/paternal name:
First/given name:

Middle name:
Maternal name (if applicable):
Other names used (e.g., former name, alias):

Gender: ☐ Male ☐ Female
Date of birth: _____/_____/______ mm dd yyyy
Age (if date of birth unknown): _______ ☐ Days ☐ Weeks ☐ Months ☐ Years

Country of birth:
Frequency of border crossing: ________ times/ ☐ Day ☐ Week ☐ Month ☐ year

Passport country/citizenship
Type of ID:
ID document #:
Visa?: ☐ Yes ☐ No

For deceased persons, go to Section 5. Otherwise, continue below.

Home address:
City:
State/province:
Zip/postal code:

Country of residence:
Home telephone:
If visiting, total duration of U.S. stay: __________ ☐ Days ☐ Weeks ☐ Months ☐ Years

Contact in U.S. - Address/hotel: ☐ Same as home address above
E-mail:

Contact in U.S. - City:
Contact in U.S. - State/territory:
Contact phone in U.S.: ☐ Cell Number of days reachable at contact phone: _______

Emergency contact name:
Emergency contact relationship:
Emergency contact phone:

Section 4. Border Crossing Information

License plate #:
State/province/country issued:
Attempted entry outside an official POE?: ☐ Yes ☐ No ☐ Unknown
Contact information collected on conveyance passengers/driver(s)?: ☐ Yes ☐ No ☐ Unknown

Crossing Type*	From (City/Country)	Departure date	To (City/Country)	Arrival date	Significant stops	Name of commercial carrier, if applicable	Bus/Train #	Seat #
Current Segment:								
Past & Upcoming Segments:								

*Crossing Type: **V**: Personal vehicle **TC**: Taxi cab **M**: Motorcycle **P**: Pedestrian/Bike **B**: Passenger bus **CC**: Commercial cargo vehicle **A**: Ambulance **T**: Train **O**: Other

Section 5. Disposition of ill/deceased person

Ill person was (check all that apply):

☐ Released to continue travel
☐ Advised to seek medical care
☐ EMS responded
☐ Recommended to not continue travel
☐ Transported to hospital (☐ MOA activated): __________________
☐ Transported to non-hospital location: _________________________
☐ Detained by law enforcement, location: _______________________
☐ Denied entry by law enforcement
☐ Other: ____

Deceased Person:

Body released to medical examiner?: ☐ Yes ☐ No

Medical examiner telephone: ___________________

City/State/Country: __________________________

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect

of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-0821