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

Form Approved
OMB Control No.0920-0134
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):	Deceased Person:
☐ 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: _____	Body released to medical examiner?: ☐ Yes ☐ No Medical examiner telephone: _____ City/State/Country: _____

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