



Land Travel Illness or Death Investigation Form

U.S. Centers for Disease Control and Prevention

Form Approved
OMB Control No.0920-0134
Exp 03/31/2022



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: <u> </u> / <u> </u> / <u> </u> <small>mm dd yyyy</small> | Time of initial notification to CDC (24 hrs): <u> </u> : <u> </u> <small>hh : mm</small> |
| Type of notification: <input type="checkbox"/> Illness <input type="checkbox"/> Death | | When was the Quarantine Station notified?: <input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> During travel <input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> After disembarking conveyance <input checked="" type="checkbox"/> While at the port as a pedestrian or in vehicle <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> Unknown | |
| Type of traveler: <input type="checkbox"/> Crew <input type="checkbox"/> Passenger <input type="checkbox"/> N/A | | | |
| Where was the traveler when the QS was notified?: <input type="checkbox"/> In U.S. jurisdiction <input type="checkbox"/> In foreign jurisdiction <input type="checkbox"/> 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)? |
|--|--------------------|--------------|--|--|--|
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, |
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, |
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, | <input type="checkbox"/> No <input type="checkbox"/> Yes, |

Relevant Vaccinations

Traveler up to date on relevant vaccinations Yes No Vaccinated with NON-WHO or NON-FDA approved vaccine Unknown

Vaccine Type: _____ ; Dose 1 date: / / Manufacturer _____ ; Dose 2 Date: / / Manufacturer _____ ; Dose 3 date: / / Manufacturer _____

Information Source: Vaccine card Medical Record Vaccine Digital Passport IATA Travel Pass State Records Traveler Recollection Other Specify: _____

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

| | | |
|--|---|---|
| <input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR feeling feverish/having chills in past 72 hrs Onset date: <u> </u> / <u> </u> / <u> </u> Current temperature: <u> </u> ⁰ F/C | <input type="checkbox"/> Sore throat Onset date: <u> </u> / <u> </u> / <u> </u> | <input type="checkbox"/> Neck stiffness Onset date: <u> </u> / <u> </u> / <u> </u> |
| <input type="checkbox"/> Rash Onset date: <u> </u> / <u> </u> / <u> </u> Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular/Pustular <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other | <input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: <u> </u> / <u> </u> / <u> </u> | <input type="checkbox"/> Decreased consciousness Onset date: <u> </u> / <u> </u> / <u> </u> |
| <input type="checkbox"/> Conjunctivitis/eye redness Onset date: <u> </u> / <u> </u> / <u> </u> | <input type="checkbox"/> Swollen glands Onset date: <u> </u> / <u> </u> / <u> </u> Location: _____ <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin | <input type="checkbox"/> Recent onset of focal weakness and/or Paralysis Onset date: <u> </u> / <u> </u> / <u> </u> |
| <input type="checkbox"/> Coryza/runny nose Onset date: <u> </u> / <u> </u> / <u> </u> | <input type="checkbox"/> Vomiting Onset date: <u> </u> / <u> </u> / <u> </u> Number of times in past 24 hrs? <u> </u> | <input type="checkbox"/> Unusual bleeding Onset date: <u> </u> / <u> </u> / <u> </u> |
| | <input type="checkbox"/> Diarrhea Onset date: <u> </u> / <u> </u> / <u> </u> Number of times in past 24 hrs?: <u> </u> | <input type="checkbox"/> Obviously unwell |
| | <input type="checkbox"/> Jaundice Onset date: <u> </u> / <u> </u> / <u> </u> | <input type="checkbox"/> Injury |
| | | <input type="checkbox"/> Chronic condition |

| | | |
|---|---|--|
| <input type="checkbox"/> Persistent cough Onset date: ____ / ____ / ____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood | <input type="checkbox"/> Headache Onset date: ____ / ____ / ____ <input type="checkbox"/> Loss of Sense of Taste or Smell Onset date: ____ / ____ / ____ | <input type="checkbox"/> Asymptomatic <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth: ____ / ____ / ____ mm dd yyyy | Age (if date of birth unknown): ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years | |
| Country of birth: | Frequency of border crossing: _____ times/ <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> year | | |
| Passport country/citizenship | Type of ID: | ID document #: | Visa?: <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years | |
| Contact in U.S. - Address/hotel: | | | E-mail: |
| | | | <input type="checkbox"/> Same as home address above |
| Contact in U.S. - City: | Contact in U.S. - State/territory: | Contact phone in U.S.: | |
| | | <input type="checkbox"/> 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?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Contact information collected on conveyance passengers/driver(s)?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

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|---|-------------------------|
| Ill person was (check all that apply): | Deceased Person: |
|---|-------------------------|

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|---|--|
| <input type="checkbox"/> Released to continue travel <input type="checkbox"/> Advised to seek medical care <input type="checkbox"/> EMS responded <input type="checkbox"/> Recommended to not continue travel <input type="checkbox"/> Transported to hospital (<input type="checkbox"/> MOA activated): _____ <input type="checkbox"/> Transported to non-hospital location: _____ <input type="checkbox"/> Detained by law enforcement, location: _____ <input type="checkbox"/> Denied entry by law enforcement <input type="checkbox"/> Other: _____ | Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> 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