

Instructions for the Maritime Conveyance Illness or Death Investigation Form

Please download this form, type the vessel name at the top of the form, and save it for future use.

Completing and submitting

- Complete this form as specified by <https://www.cdc.gov/port-health/php/maritime-guidance/reporting-death-or-illness-on-ships.html>
 - To ensure the form is submitted correctly:
 - Start with a new blank form for each ill or deceased person you are reporting. It may be helpful to bookmark this web address: <https://www.cdc.gov/port-health/media/pdfs/The-Maritime-Conveyance-Illness-or-Death-Investigation-Form.pdf>
 - Do not use a form that has been previously filled out.
 - Note that all fields with **red text and an asterisk symbol (*)** are required. These fields include: Person filling out form, E-mail, Type of notification, Type of traveler, Conveyance type, Vessel company/name (**If ship not listed select “Other” in the dropdown menu and type in the ship name**), Country of departure, Departure date, Next U.S. port and state, Arrival date at next U.S. port, Embarkation port, Embarkation date, at least one Sign, Symptom, or Condition, and Presumptive diagnosis/cause of death.
 - Please note that for some questions (temperature unit, rash type, cough type, chest x-ray result, and presence of cavity) you won't be able to clear your selection by unclicking the box. To clear your selection you should click on the green default circle located to the right of the main selections. For example, if 'cavity' is checked in error, you may clear the selection by clicking the green default circle to the right of 'no cavity.' See images below.
- Cavity No cavity
- Cavity No cavity

- For more information about the fields on this form, visit: <https://www.cdc.gov/port-health/php/maritime-guidance/explanation-of-key-fields-in-maritime-conveyance-illness-or-death-investigation-form.html>
- Submit to the **CDC port health station** with jurisdiction over the **next U.S. seaport of arrival** by one of the methods described below.

Instructions by section

Sections 1–4 (Port Health Station Notification, Vessel Information, Medical History, and Evaluation of Ill or Deceased Person)

- To complete **Sections 1–4**, you may type directly into the form, or print and fill out by hand.
- To submit the form, choose from the following options:
 1. Click on the gray **“Send Via E-mail”** button in the upper left-hand corner of the form (Note: In order to use this option, your e-mail account must be set up to automatically generate an e-mail message from a PDF), or save the form, then attach to your e-mail and send it to MaritimeAdmin@cdc.gov, or
 2. Look up the contact information for the **CDC port health station** with jurisdiction over the next U.S. seaport of arrival at <https://www.cdc.gov/port-health/stations/port-health-station-contact-list.html> and send by **fax**, or
 3. By **telephone**.
- A confirmation e-mail will be sent to the e-mail address that was entered on the form within 1-2 business days. The **port health station** will contact you if follow-up information is needed.
- If you don't receive confirmation of your report, or if you have any questions, please contact the **CDC port health station** with jurisdiction) for the next U.S. port of arrival, the CDC Emergency Operations Center at 770-488-7100, or the Maritime Activity Administrator (MaritimeAdmin@cdc.gov).

Section 5 (General Information About Ill or Deceased Person)

- **Please DON'T submit Section 5 unless the port health station asks you to do so.**
- To complete **Section 5**, **print out** the form and **fill in by hand**. This section contains personally identifiable information (PII), so you won't be able to type into the fillable PDF form.
- **Submit by encrypted or password-protected email or telephone only.**

PII is any information that can be used alone or in combination to identify an individual. This includes names, addresses, phone numbers, dates (birth, hospital admission, travel), identifying numbers (passport, social security, driver's license, alien), medical records, photographs **that show the face**, and for rare diseases, geographic locations.

Reminders to cruise ships

1. CDC requests cumulative reporting of acute respiratory illness (ARI) cases (including zero) for each voyage preferably within 24 hours before arrival in the U.S. and sooner if a voyage's crew or passenger ARI attack rate reaches 3% by completing the Cruise Ship Cumulative Acute Respiratory Illness Reporting Form. See https://www.cdc.gov/port-health/php/maritime-guidance/guidance-for-cruise-ships-on-management-of-acute-respiratory-illness-ari-due-to-viral-infection.html#cdc_generic_section_15-reporting
2. Send gastrointestinal (GI) illness reports to CDC's Vessel Sanitation Program (VSP). For more information call 800-323-2132 or visit <https://www.cdc.gov/vessel-sanitation/about/>
3. Report a case of Legionnaires' disease by sending an e-mail to travellegionella@cdc.gov.

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Send Via Email

Reset Form

Maritime Conveyance Illness or Death Investigation Form

U.S. Centers for Disease Control and Prevention

Section 1. Port Health Station Notification

Person filling out form (*):		Phone:		E-mail (*):	
Type of notification (*): Illness Death	Type of traveler (*): Crew Passenger	Conveyance type (*): Cruise ship Cargo Other			

Section 2: Vessel Information

Vessel company/name (*):		Voyage number:		Number on board: Crew: Passengers:	
Country of departure (*):	Departure date (*) & time (24 hr): mm / dd / yyyy hh : mm	Arrival date & time (24 hr) at final port: mm / dd / yyyy hh : mm			
Itinerary:					
Next U.S. port (*):			Arrival date (*) & time (24 hr) at next U.S. port : mm / dd / yyyy hh : mm		
Person information while onboard vessel:					
Cabin number:	If crew, list job title & duties:		If crew member has contact with passengers, describe extent/frequency:		
Embarkation port (*):	Embarkation date (*): mm / dd / yyyy	Disembarkation port:		Disembarkation date: mm / dd / yyyy	

Section 3: Medical History

Age (___ years vs. ___ months):	Include relevant medical history of ill or deceased person (present illness, other medical problems, vaccinations, overseas physician diagnosis, etc.):
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Signs, Symptoms, and Conditions (*) [Check all that apply] :

<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR history of feeling feverish/ having chills in past 72 hrs Onset date: ___/___/___ Current temperature: ___ $^{\circ}$ F/C <input checked="" type="checkbox"/>	<input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: ___/___/___	<input type="checkbox"/> Decreased consciousness Onset date: ___/___/___
<input type="checkbox"/> Chest pain Onset date: ___/___/___	<input type="checkbox"/> Swollen glands Onset date: ___/___/___ 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: ___/___/___ Describe (e.g., where weakness/paralysis started and how it progressed):
<input type="checkbox"/> Rash Onset date: ___/___/___ Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular <input type="checkbox"/> Pustular <input checked="" type="checkbox"/> <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other <input type="checkbox"/> Erythema <input type="checkbox"/> Wheals	<input type="checkbox"/> Nausea Onset date: ___/___/___	<input type="checkbox"/> General pain Onset date: ___/___/___ Describe:
<input type="checkbox"/> Muscle pain Onset date: ___/___/___	<input type="checkbox"/> Neck stiffness Onset date: ___/___/___	<input type="checkbox"/> Unusual bleeding or bruising Onset date: ___/___/___ Describe:
<input type="checkbox"/> Conjunctivitis/eye redness Onset date: ___/___/___	<input type="checkbox"/> Vomiting Onset date: ___/___/___ # of times in past 24 hrs:	<input type="checkbox"/> Obviously unwell
<input type="checkbox"/> Coryza/runny nose Onset date: ___/___/___	<input type="checkbox"/> Diarrhea Onset date: ___/___/___ # of times in past 24 hrs:	<input type="checkbox"/> Injury Date: ___/___/___ Describe:
<input type="checkbox"/> Persistent cough Onset date: ___/___/___ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood <input checked="" type="checkbox"/> <input type="checkbox"/> Dry <input type="checkbox"/> Productive	<input type="checkbox"/> Jaundice Onset date: ___/___/___	<input type="checkbox"/> Chronic condition Onset month/year: ___/___ Describe:
<input type="checkbox"/> Dizziness Onset date: ___/___/___	<input type="checkbox"/> Headache Onset date: ___/___/___	<input type="checkbox"/> Other signs, symptoms, conditions:
<input type="checkbox"/> Sore throat Onset date: ___/___/___	<input type="checkbox"/> Malaise Onset date: ___/___/___	

Deceased person's:	Date of death:	Time of death (24 hours):
	mm / dd / yyyy	hh : mm
Circumstances of death:		
Presumptive diagnosis/cause of death (*):		
During the past 3 weeks, has anyone (onboard ship or disembarked) had similar signs and symptoms? (Please verify by a medical log review):	No	
If yes, please fill in a new form for each person in the cluster	Yes, total # ill of crew:	total # ill of passengers:
	Unknown	

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Section 4. Evaluation of Ill or Deceased Person

Traveler has taken (include those given on board):

Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with dates started:

Fever-reducing medications (e.g., acetaminophen, ibuprofen) in the **past 12 hours**; list with dates started:

Other (related to current symptoms/illness); list with date(s) started:

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

Number of potentially exposed contacts (e.g., cabin, work, bathroom mates):

Are any traveling companions ill? No Yes*, how many are ill: N/A (no companions)

If passenger is a child, does s/he attend day care/youth program on ship?

No Yes, total # of children in day care/program: # of children with similar signs & symptoms*:

Note: Submit a separate form for each ill or deceased person not previously reported to a CDC **Port Health Station.*

Seen in ship infirmary?

No
Yes, date of first visit: mm / dd / yyyy
No infirmary

Ill/deceased person isolated after illness onset?

No
Yes, date isolated: mm / dd / yyyy

Seen in health-care facility ashore?

No
Yes; facility/health care provider(s) information (name, location, dates, telephone number, e-mail):

Hospitalized?

No
Yes, dates hospitalized: from to mm / dd / yyyy

Lab/Imaging Results

Tests	Date performed (mm/dd/yyyy)	Results (if unknown, provide name and phone number of lab/facility which performed tests/imaging)
Chest x-ray:		Normal Abnormal <input checked="" type="radio"/> (Cavity <input checked="" type="checkbox"/> No cavity <input checked="" type="checkbox"/>)
<i>Legionella</i> urine antigen:		Positive Negative
Test 1:	1.	1.
Test 2:	2.	2.
Test 3:	3.	3.

Deceased persons:

Body released to medical examiner?: No Yes Telephone: City/Country:

Discharge/final diagnosis/cause of death (determined by medical examiner or other):

Section 5. General information about ill or deceased person				
Last/paternal name:		First/given name		
Middle name:		Maternal name (if applicable):		Other names used (e.g., former name, alias):
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth: _____ mm/dd/yyyy		
Country of birth:	Passport country/citizenship:	Type of ID document:	ID document #:	Alien #:
Home address:		City:	State/province:	Zip/postal code:
Country of residence:		Home phone:	If visiting, total duration of U.S. stay: Days Months Weeks 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 # of days reachable at contact phone: _____
Emergency contact name:		Emergency contact relationship:		Emergency contact phone:
Comments:				

TO BE COMPLETED BY PORT HEALTH STAFF ONLY			
PHARS Unique ID #:	CDC User ID:	Date Port Health Station notified:	Time Port Health Station notified (24 hrs):
When was the Port Health 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		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 (<input type="checkbox"/> MOA activated): _____ Transported to non-hospital location: _____ Detained by law enforcement, location: _____ Denied boarding by law enforcement Other: _____	
Where was the traveler when the PHS was notified?: In U.S. jurisdiction (within 3 nautical miles of U.S. coast or traveling Outside U.S. jurisdiction Unknown		Response or Info Only: Requires DGMH Response & Follow-Up Information Report Only / No Follow-Up Needed	
NOTE: If ill/deceased person also traveled via Land and/or Air conveyances, please fill out the appropriate form			

Sections 1-4: Public reporting burden of this collection of information is estimated to average 10 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 0920-1335.

Section 5: 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 0920-1335.

Vessel Company/Name:	Country of departure:	Departure date:
Presumptive Diagnosis:		