NOAA DIVING PROGRAM

DIVE ACCIDENT MANAGEMENT
FIELD REFERENCE GUIDE

NOAA Diving Center
7600 Sandpoint Way NE
Seattle, WA 98115

Updated October 2018

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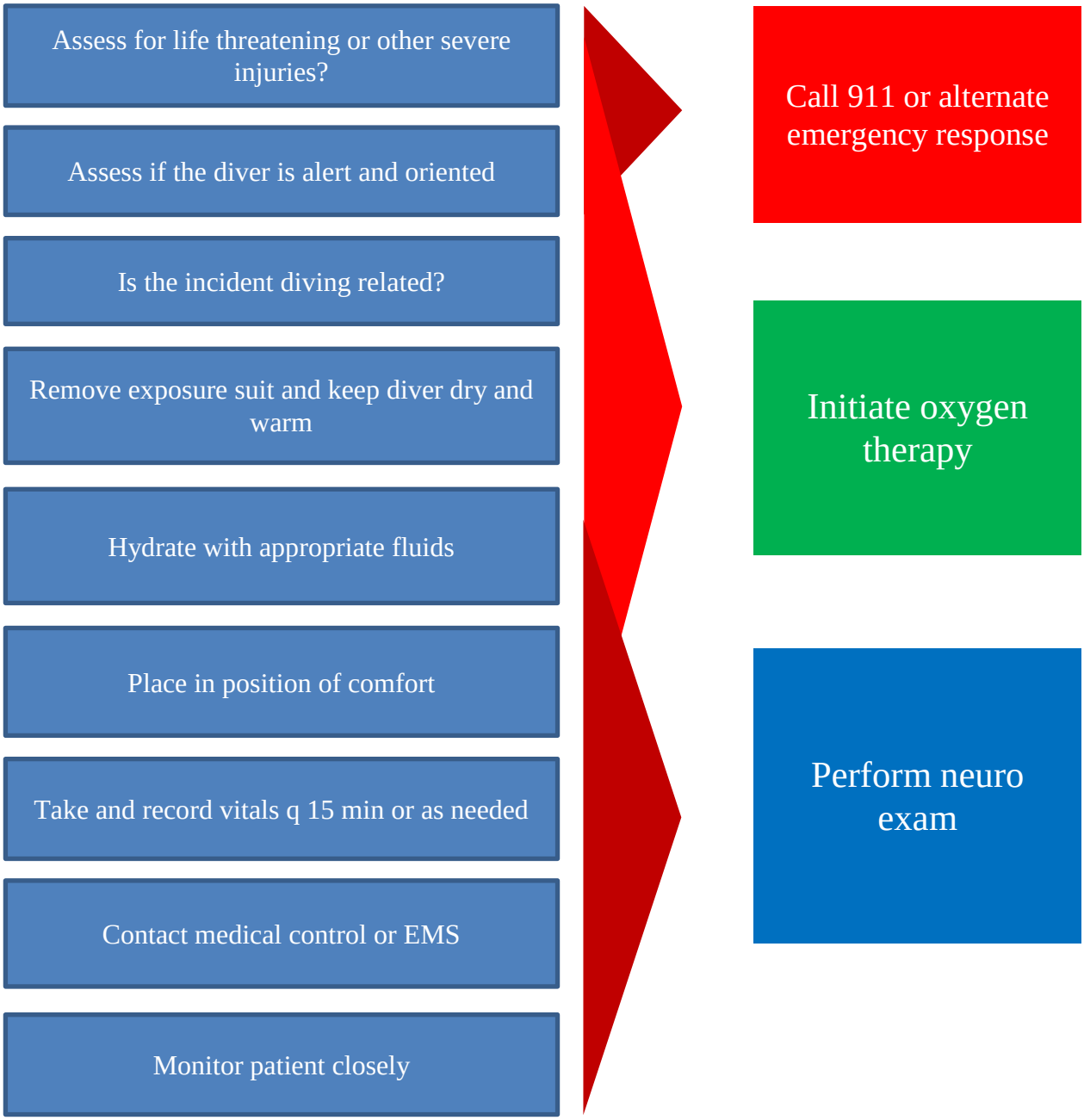
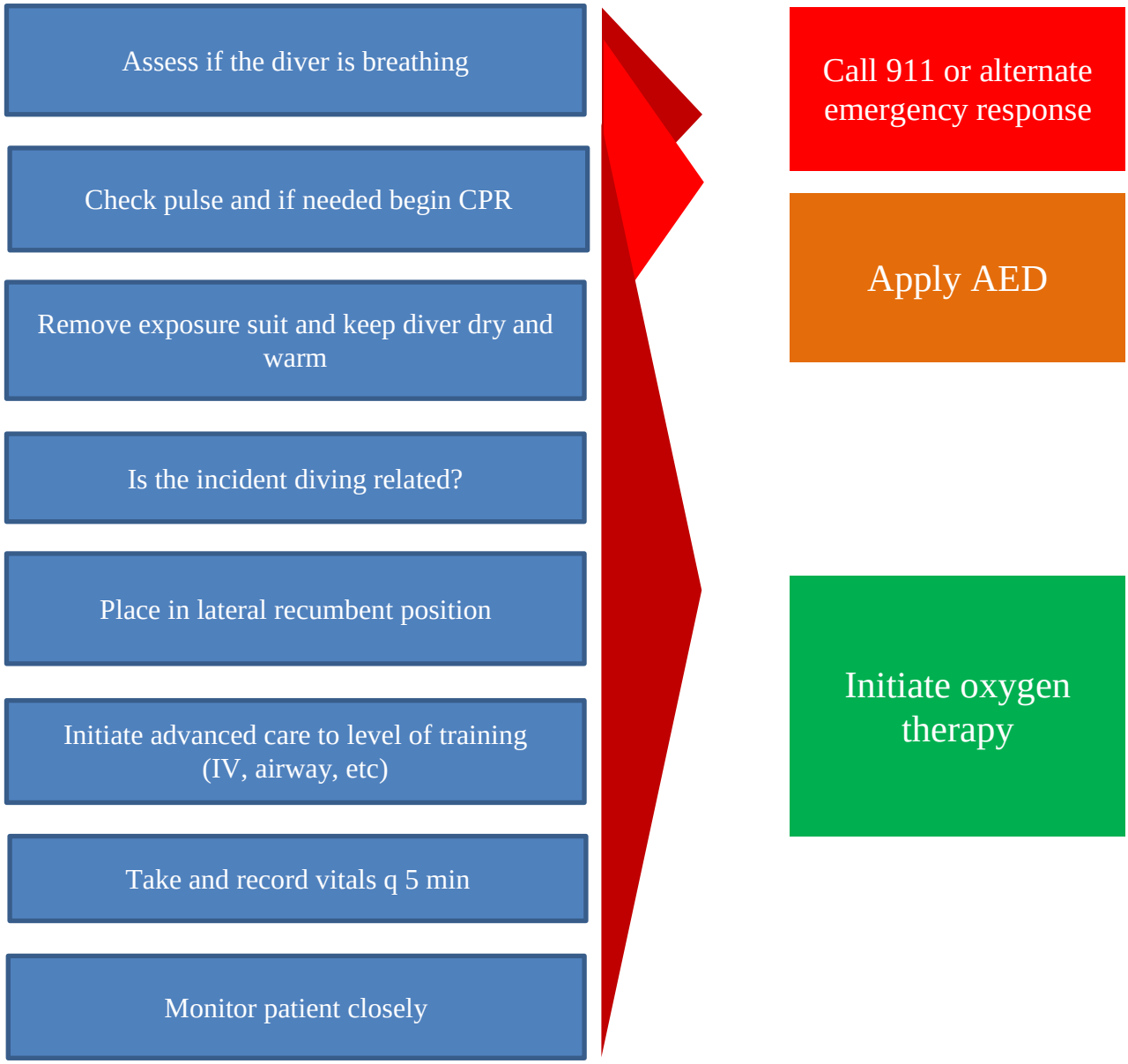
Treatment of the Conscious Diver



Treatment of the Unconscious Diver



Sign and Symptoms of DCS

Type I DCS

Musculoskeletal

- Discomfort or abnormal feeling in or near a joint.
- Constant aching pain, usually not tender to touch or movement.
- No outward change in appearance

Skin

- Itching
- Rash
- Localized swelling of the skin
- Marbling (patchy blue and pink areas) – Cutis Marmorata – Not simple skin bends and may require treatment

Lymphatic

- Swelling of extremity
- Pain in the area of swelling

Type II DCS

Neurologic

- Headache
- Numbness or tingling
- Weakness or paralysis
- Nausea
- Loss of bowel or bladder control
- Extreme fatigue
- Visual disturbances
- Difficulty standing or walking
- Chest pain
- Shortness of breath
- Behavioral changes
- Feeling of something's wrong

Vestibular (inner ear)

- Hearing loss
- Tinnitus (ringing in the ears)
- Vertigo
- Nausea/vomiting
- Lack of coordination

Pulmonary

- Chest tightness
- Difficulty breathing
- Chest pain
- Rapid breathing
- Abnormal breath sounds

Signs and Symptoms of AGE

Symptoms occur at or near the surface or generally within 10 minutes of surfacing

- Extreme fatigue
- Difficulty in thinking
- Vertigo
- Nausea and/or vomiting
- Hearing abnormalities
- Bloody sputum
- Loss of control of bodily functions
- Tremors
- Loss of coordination
- Loss of consciousness
- Cardiopulmonary arrest
- Other stoke like symptoms

Oxygen Toxicity

V – Visual disturbances

E – Ears (ringing, extraneous noises)

N – Nausea

T – Twitching/Tingling

I – Irritability

D – Dizziness

CON - Convulsions

NOAA DIVER CONTACT INFORMATION

Name of Diver: _____ DOB: _____

Present Address: _____ Zip: _____

Height: _____ Weight: _____ Age: _____ Sex: M F

Home Phone: _____ Work: _____ Cell: _____

Present Employer: _____

Significant Medical History / Allergies: _____

_____

Preferred contacts in event of an emergency:

Name:_____ Phone: _____

Name:_____ Phone: _____

DIVE HISTORY

Date: _____ Time of Day: _____ Depth: _____ Bottom Time: _____

Breathing Gas: _____ Equipment Used: _____

Did anything unusual occur prior to or during dive? If so, describe

_____

If repetitive, list specifics of previous dives in past *24* hours:

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Location at time of injury: _____Time of onset: _____

Was symptom noticed before, during, or after the dive? _____

If during, was it while descending, on the bottom, or ascending? _____

Has symptom increased or decreased since first noticed? _____

Diver's description of symptoms (include location, type, quality, etc.)

_____

ADDITIONAL DIVE HISTORY

Does pain radiate? If so, where from _____to _____

Does pain increase with movement or palpation? _____

Have any other symptoms occurred since the first one was noticed? If so, describe ___

_____

Has patient ever had a similar symptom? If so, describe _____

_____

Has patient ever had DCS or AGE before? If so, note when and describe: _____

_____

Dive Buddy's comments: _____

_____

_____

ADDITIONAL BACKGROUND INFORMATION

Does the patient smoke? yes ____ no ____

Has there been any recent exposure to altitude? yes ____ no ____

Are there any dive-related problems that could explain the present symptoms? _____

_____

Current medication list: _____

List all medications taken during the previous 24-hours _____

_____

If the diver is female, when was her last menstrual cycle?_____

When did the diver last eat and drink? _____

Describe the activities performed during the dive: _____

_____

_____

Describe the activities performed following the dive: _____

_____

_____

NOAA NEUROLOGIC EXAM FOR DIVING CASUALTIES

Name: _____ Date/Time: _____

Describe symptom: _____

_____

Dive Profile: D/BT _____ / ___ SI ____ min D/BT_____/_____SI_____min D/BT____ / ___ SI ____ min D/BT ____ /_____

MENTAL STATUS/STATE OF CONSCIOUSNESS

(Circle one)

A = Awake and alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

Knows: person ___ place ___ time___ year ___
Can add nickel, quarter, and dime? ____
Recite 3 unrelated objects after wait? _____
Speech: ___ normal ___ abnormal

Identify objects? _____
Glasgow Coma Scale score: _____

VITAL SIGNS Pulse/min _____ Respirations _____ Blood Pressure _____ Temp (warm, cool, normal)

COORDINATION (Normal/Abnormal)

Walk: _____
Heel-to-toe: _____
Romberg: _____
Finger-to-nose: _____
Heel-shin slide: _____
Rapid movement:_____

STRENGTH

Graded 0-5:

0 = Paralysis (no motion possible)
1 = Profound weakness (trace of muscle contraction)
2 = Severe weakness (muscle contraction but not against gravity)
3 = Moderate weakness (can overcome gravity but not resistance)
4 = Mild weakness (able to resist slight force)
5 = Normal (equal strength, able to resist force)

CRANIAL NERVES (Normal/Abnormal)

Sense of smell (I) _____
Vision/visual field (II) _____
Eye movements, pupils (III, IV, VI) _____
Facial sensation, chewing (V) _____
Facial expression muscles (VII) _____
Hearing (VIII) _____
Upper mouth, throat sensation (IX) _____
Gag and voice (X) _____
Shoulder shrug (XI) _____
Tongue (XII) _____

Upper body: Deltoids: L _____ R_____
Latissimus: L_____ R_____
Biceps: L_____ R_____
Triceps: L_____ R_____
Forearms (grip): L_____ R_____
Hands (finger spread): L_____ R_____
Lower body: Hips - Flexion: L_____ R_____
Extension: L_____ R_____
Abduction (spread): L_____ R_____
Adduction(squeeze): L_____ R_____
Knees - Flexion: L_____ R_____
Extension: L_____ R_____
Ankles - Doriseflexion: L_____ R_____
Plantarlfexion: L_____ R_____

REFLEXES

Grade: (0-absent, 1-hypoactive, 2-normal, 3-hyperactive)

Biceps: L_____ R_____ Forearm: L_____R _____Knees: L_____ R _____ Ankles: L_____ R_____

DESCRIBE ALL ABNORMAL FINDINGS: _____

_____

_____

_____

Glasgow Coma Scale

Eye Opening	
Spontaneously	4
To verbal command	3
To painful stimulus	2
None	1

Verbal Response	
Talking/Oriented	5
Confused/Disoriented	4
Inappropriate words	3
Incomprehensible words	2
None	1

Motor Response	
Obeys commands	6
Localizes to pain	5
Withdraws from pain	4
Abnormal Flexion	3
Abnormal extension	2
None	1

NEUROLOGIC EXAMINATION
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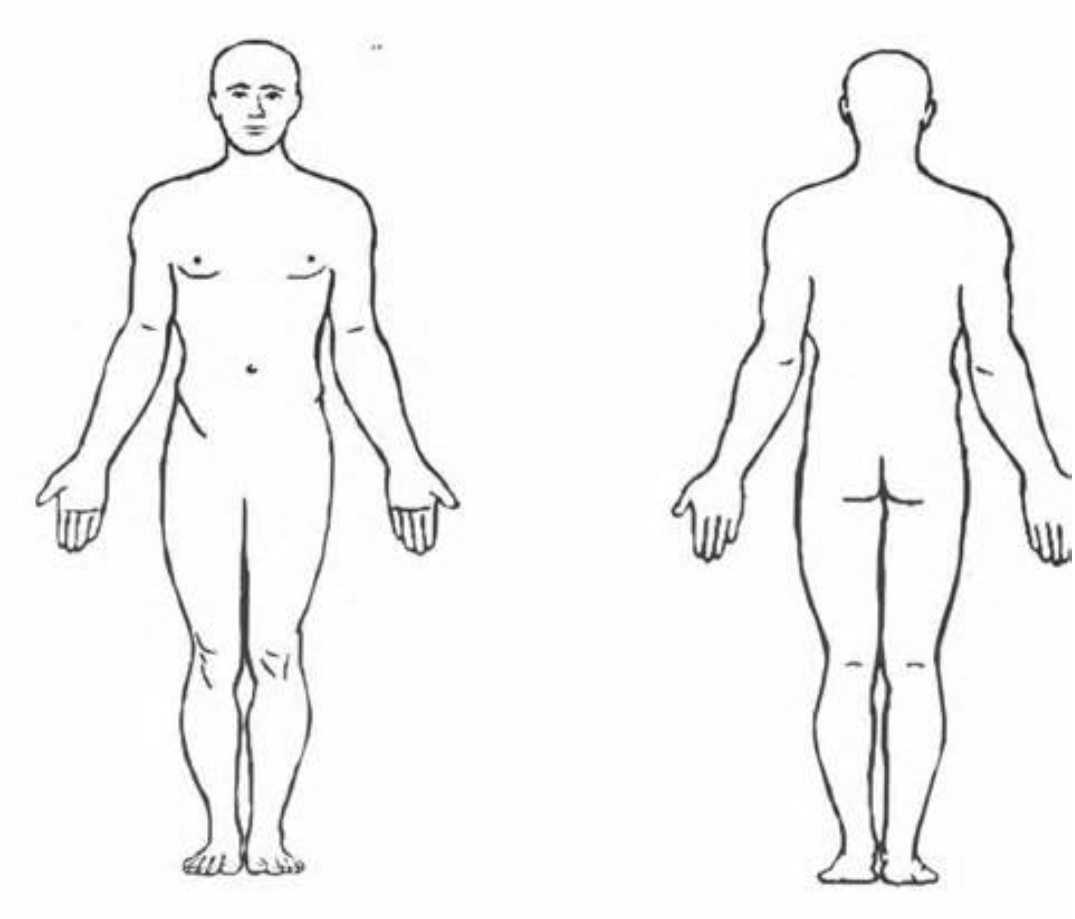


SENSORY EXAMINATION FOR SKIN SENSATION
(Check for sharp, dull, light touch sensation; use diagram to record location of numbness/tingling, pain)

LOCATION

Comments: _____
_____
_____
_____
_____
_____
_____
_____

_____	_____	_____	_____
Examiner (print)	Signature	Title	Date

TREATMENT NOTES

GLASGOW COMA SCALE

I. Motor Response
- 6 - Obeys commands fully
- 5 - Localizes to noxious stimuli
- 4 - Withdraws from noxious stimuli
- 3 - Abnormal flexion, i.e. decorticate posturing
- 2 - Extensor response, i.e. decerebrate posturing
- 1 - No response

II. Verbal Response
- 5 - Alert and Oriented
- 4 - Confused, yet coherent, speech
- 3 - Inappropriate words, and garbled phrases consisting of words
- 2 - Incomprehensible sounds
- 1 - No sounds

III. Eye Opening
- 4 - Spontaneous eye opening
- 3 - Eyes open to speech
- 2 - Eyes open to pain
- 1 - No eye opening

Glasgow Coma Scale = I + II + III. A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 is a moderate injury, and 8 or less a severe brain injury.

EMERGENCY CALL-IN SCRIPT

“I am a NOAA Divemaster and I am calling to report a diving-related emergency requiring immediate medical assistance. The victim is a _____ (age) year old _____ (gender) who is _____ (conscious/unconscious), with the following symptoms after diving with compressed gas…… (describe pain, dizziness, etc.)”

“We have placed the victim in the supine position, and have initiated basic first aid. We have also completed a field neurological exam, with the following results……. (note any deficits). The victim is on 100% oxygen by mask, and we have rendered the following additional treatment……. (CPR, IV fluids, medications, etc.) Last vital signs are as follows…...”

Temp: ____ Pulse: ____ Resp: ____ B/P: ____/____

“ We are at the following location……(location of diver / landmarks) and request immediate medical transport to……. (receiving facility of choice) via (air / ground) transport”

Note: Do not terminate call….the receiving unit will end the call.

CONTACT INFORMATION

MEDICAL

Local EMS .....(911)
USCG .....VHF Channel 16
On-Call DMO.....(855) 822-3483
(206) 526-6986
LCDR Gary Montgomery (non-emergency).....(206) 256-6430
(830) 624-6283
MOC-P Medical Officer on call..... (206) 409-8725 (cell)
MOC-A Medical Officer on call..... (757) 615-6619 (cell)
Diver's Alert Network (DAN).....(919) 684-9111

ADMINISTRATIVE CONTACTS

Greg McFall, NOAA Diving Program Director ..... (305) 809-4713 (work)
(912) 596-2464 (cell)
David Kowalick, NOAA Diving Center Manager ..... (206) 526-6476 (work)
(206) 817-9792 (cell)

Roger Mays, NOAA Diving Safety Officer ..... (301) 525-7380 (work)
(252) 723-1612 (cell)

CHAMBER LOCATIONS & QUALIFIED PHYSICIANS (Seattle, WA)

Primary: Virginia-Mason Medical Center
1202 Terry Ave., Seattle, WA
Hyperbaric Department: (206) 583-6543
24-hour emergency line: (206) 583-6433

Secondary: Diver's Institute of Technology
1341 Northlake Way, Seattle, WA
Chamber phone: (206) 783-5542

Tertiary: St. Joseph's Medical Center – Tacoma
Hyperbaric Medical Service: (253) 426-6630
24-hour emergency line: (253) 426-6630

Additional Assistance: Divers Alert Network
24-hour emergency line: (919) 684-9111

CONTACT INFORMATION CON'T.

OTHER TRANSPORTATION CONTACTS

U.S. Coast Guard – Boat or Helicopter
(206) 220-7001 or (800) 982-8813
VHF Ch-16 or SFD dispatch

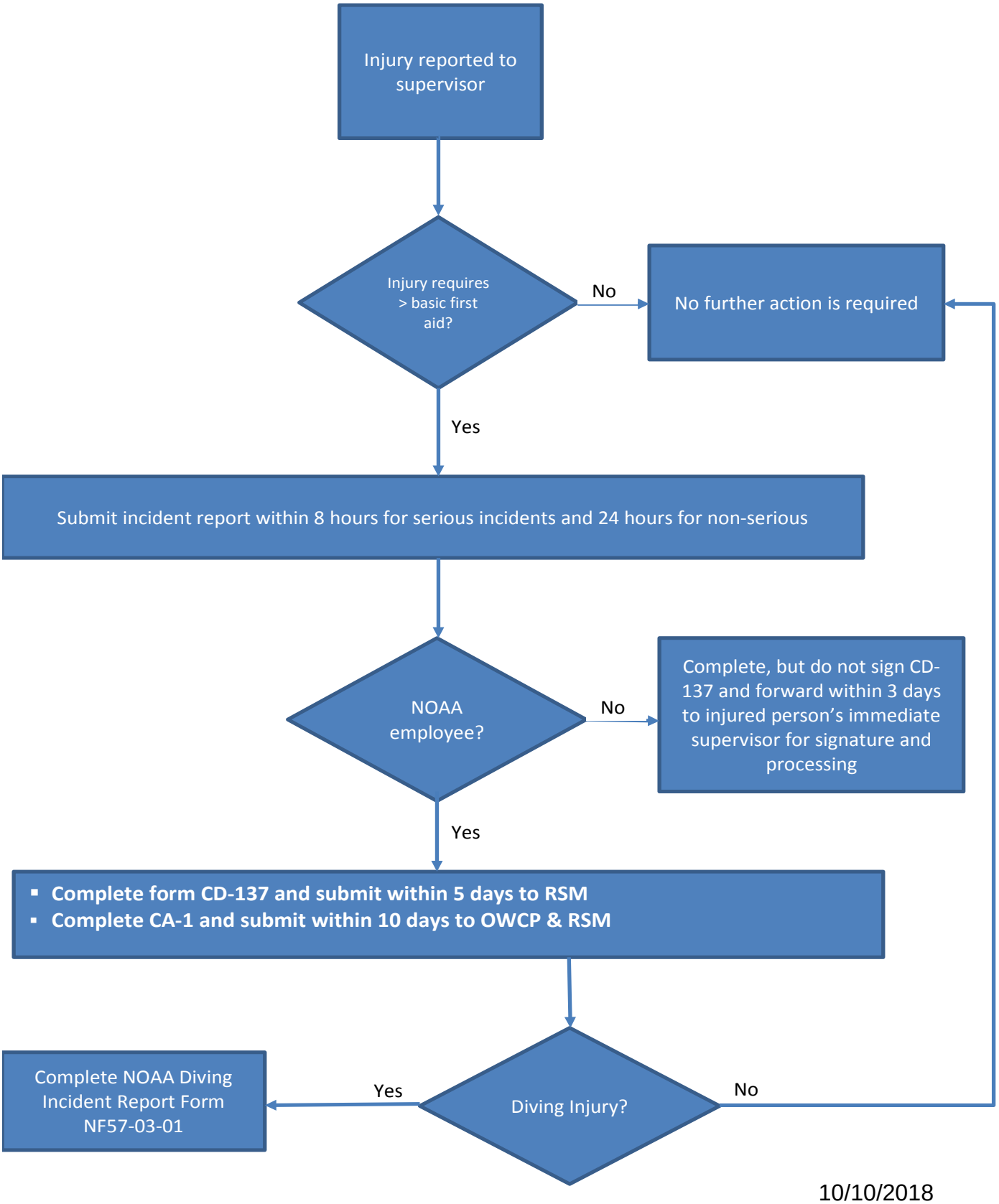
SPD Harbor Patrol
(206) 684-4071
VHF Ch-16 or SFD dispatch

King County Marine Unit
911 or (206) 296-3311
VHF Ch-16 or SFD dispatch

Mercer Island Police / Fire
Rescue (206) 236-3600
VHF Ch-16 or SFD dispatch

Airlift Northwest
(206) 329-2569

NOAA DIVING PROGRAM
ACCIDENT MANAGEMENT & REPORTING PROCEDURES



10/10/2018

Revised: February 2004

TO: LO Management,
CC: NOAA Safety Director, RSM

Complete **the form then email to appropriate parties.** Forward completed form within 24 hours of a job related injury, illness or near-miss. **Note:** Save to your Desktop**.**

Immediate Notification Report

Supervisor Completing Form	
Job Title	
Last/First/Middle Name	
Facility	
Telephone Number	
Injured Employee or Affected Property Information	
Work Location	
Job Title	
Last/First/Middle Name	
Telephone Number	
Property Identification	
Date/Time of Accident Occurrence	
Location of Accident	
Accident Type (injury/death/equipment)	
Description of Mishap	
Facility Corrective/Preventative Actions Implemented in Response to Accident	
Preventative Action Recommendations	
Additional Comments	
Date/Time Form Completed/Submitted	

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle) | 2. Social Security Number

3. Date of birth Mo. Day Yr. | 4. Sex ☐ Male ☐ Female | 5. Home telephone | 6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and ZIP code) | 8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr. | Time ☐ a.m. ☐ p.m. | 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code
b. Type code | c. Source code
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

32. Name and address of physician first providing medical care (Include city, state, ZIP code)

33. First date medical care received Mo. Day Yr.

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor | Date

Supervisor's Title | Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Form CA-1,

Rev. Apr. 1999

FORM CD-137
(Rev. 5/89) LF
DAO 209-4

U.S. DEPARTMENT OF COMMERCE

Report of Accident/Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

Case: _____ Control: _____
Date Received: _____
Type/Source: _____ / _____
Org. Code: _____

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report: ☐ Accident ☐ Illness
2. Name: _____ (Last, First, M.I.) 3. SSN: _____
4. Occupation: _____ 5. Phone: _____
6. Date of Birth: _____ 7. Sex: ☐ Male ☐ Female
8. Date/Time of Accident/Illness: _____ Time: _____ ☐ AM ☐ PM
9. Duty Station Address:
10. Location of Incident:
11. Description of Incident:
12. Extent of Injury or Illness and Body Parts Affected:

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

13. Medical Treatment? ☐ Yes ☐ No 14. Lost Time? ☐ Yes ☐ No
15. Investigator's Name: _____ 15. Investigation Date: _____
16. Findings:
17. Amount of Property Damage: $ _____
18. Corrective Action:
19. Completion Date: _____ ☐ Estimated ☐ Actual

Investigator's Signature: _____ Date: _____
Title: _____ Phone: _____

Distribution: Original; Employee Supervisor; Employee; Safety Representative.
ADMINISTRATION/IPSG ELECTRONIC FORM

NOAA Form 57-03-01
(1-13) Page 1 of 2

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

DIVING INCIDENT REPORT

NOTE: The Unit Diving Supervisor (UDS) shall use this form to report serious diving related injuries, including near-drowning, arterial gas embolism (AGE), decompression sickness (DCS), pulmonary barotrauma, or any diving injury that requires hospitalization. An additional narrative and detailed analysis of the incident must be attached. Contact the NOAA Diving Center (NDC) to determine whether an event or minor injury requires an incident report.

DIVER NAME		TIME of INCIDENT	DATE of INCIDENT
DIVER CERTIFICATION	DIVE UNIT	LOCATION of INCIDENT	
DIVER CURRENT MEDICATIONS		DIVER CURRENT HEALTH PROBLEMS	

AGE	SEX (M/F)	HIGHEST DIVE CERTIFICATION LEVEL	CERTIFYING DIVING ASSOCIATION
TOTAL # of YEARS DIVING	TOTAL # of DIVES	TOTAL # of DIVES in the PAST 6 MONTHS	PREVIOUS DIVE INCIDENTS and DATES

BREATHING LOOP	DIVER DRESS	DIVE CYLINDER TYPE and SIZE	CYLINDER PRESSURE IN	SEP ISSUED EQUIPMENT?
☐ Open Circuit ☐ Semi Closed / Closed Circuit ☐ Surface Supplied ☐ Snorkel	☐ None / Dive Skin ☐ Wet Suit Thickness _____ ☐ Dry Suit	BREATHING GAS	CYLINDER PRESSURE OUT	☐ YES ☐ NO DIVER FAMILIAR WITH EQUIPMENT? ☐ YES ☐ NO

NAME of ON-SITE DIVING SUPERVISOR / LEAD DIVER	AIR TEMP (°F)	WATER TEMP (°F)	U/W VISIBILITY (FT)	CURRENT SPEED (KTS)
NAME of DIVE BUDDY	DIVE PURPOSE	DIVE LOCATION		
DIVE BUDDY AFFILIATION	DIVE PLATFORM	SURFACE CONDITIONS		

# of DIVES on DAY of INCIDENT	# of DIVES on PREVIOUS DAY	TYPE of DIVE	DIVES CONDUCTED WITH
		☐ DUTY ☐ non-DUTY	☐ Dive Tables ☐ Dive Computer (Model_____)

Was this dive typical of the diver's normal type of diving? ☐ YES ☐ NO	If NO, explain:
Describe any problems encountered during the incident dive or previous dives:	

Dive #	Start Time	Max Depth (Feet)	Bottom Time (Minutes)	End Time	Surface Interval (HH:MM)	Deco Stop? (Y/N)	Safety Stop? (Y/N)	Stop Profile (Depth / Time)	Cold or Arduous? (Y/N)	Fast Ascent? (Y/N)	Incident Dive? (Y/N)
1.											
2.											
3.											
4.											
5.											
6.											

NOAA Form 57-03-01
(1-13) Page 2 of 2

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

DIVING INCIDENT REPORT FORM

SECTION V. EMERGENCY PROCEDURES

YES	NO		YES	NO	
☐	☐	Was emergency oxygen available on-site?	☐	☐	Was there a dive accident management plan in place for dive site?
☐	☐	Were emergency scenarios discussed with all divers prior to diving operations, such as low air, out of air, lost buddy, etc.?	☐	☐	Was the dive accident management plan reviewed by all divers and support personnel prior to diving operations?

SECTION VI. SYMPTOMS, PRE-DIVE HEALTH, and ON-SITE MEDICAL TREATMENT

DATE of SYMPTOM ONSET	DESCRIPTION of SYMPTOMS and LOCATION on BODY		
TIME of SYMPTOM ONSET			
DESCRIPTION of PRE-DIVE HEALTH		DESCRIPTION of PRE-DIVE ALCOHOL CONSUMPTION (previous 24 hours)	
DESCRIPTION of PRE-DIVE REST or FATIGUE LEVELS		DESCRIPTION of STRENUOUS EXERCISE (6 hours prior and 12 hours post-dive)	
SUSPECTED INJURIES or ILLNESSES ☐ AGE ☐ DCS ☐ Pulmonary Barotrauma ☐ Other Barotrauma ☐ None ☐ Other _____	ON-STE OXYGEN ADMINISTRATION Delivery Method	ON-SITE FIRST-AID TREATMENT PROVIDED	
	Time Started	INITIAL EMERGENCY CONTACT (name of person or agency)	
	Time Stopped	TIME of INITIAL EMERGENCY CONTACT	TIME TRANSPORTATION STARTED
FIRST-AID TREATMENT PROVIDED DURING TRANSPORT		EMERGENCY TRANSPORT METHOD(S)	

SECTION VII. MEDICAL INFORMATION – Hospital (Attach all Emergency Room, Hyperbaric Unit, and follow-up medical records.)

HOSPITAL NAME and ADDRESS	HOSPITAL TREATMENT	DATE of ARRIVAL	
		TIME of ARRIVAL	
HYPERBARIC UNIT NAME and ADDRESS	CHAMBER TYPE ☐ Monoplace ☐ Mulitplace	CHAMBER TREATMENT Treatment #1 Time Started _____ Time Stopped _____ Treatment #2 Time Started _____ Time Stopped _____ Treatment #3 Time Started _____ Time Stopped _____	
TREATMENT TABLE / DESCRIPTION	TABLE EXTENSIONS	RETREATMENT TABLE / DESCRIPTION	

DESCRIBE WHEN RELIEF FROM SYMPTOMS OCCURED	DESCRIBE ANY RESIDUAL SYMPTOMS AFTER TREATMENT	DAYS of RESIDUAL SYMPTOMS	FINAL DIAGNOSIS ☐ DCS I ☐ AGE ☐ Pulmonary Barotrauma ☐ DCS II ☐ Other _____

SECTION VIII. CERTIFICATION

UDS NAME	UDS SIGNATURE	DATE

NOTE: A Diving Incident Report shall be completed by the UDS and submitted to their Line Office Diving Officer (LODO) within 10 days of the diving incident. A full report includes the following items:

1. Diving Incident Report Form (NOAA Form 57-03-01)
2. Cover memorandum providing a narrative of the diving incident, including causal analysis and recommendations for prevention of future injuries.
3. Medical records associated with any medical treatment of injuries resulting from this incident.

The LODO shall submit the UDS report, along with their own causal analysis and recommendations for prevention of future injuries to the Director, NOAA Diving Program within 30 days of the diving incident.

RESET